

may be filled out by the funeral director, or by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McDaniel</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McDaniel</b>			
c. LENGTH OF STAY IN 1b <b>Life</b>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SARAH F. Adams</b>				4. DATE OF DEATH <b>Dec. 13, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 23, 1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James H. Turpin</b>				14. MOTHER'S MAIDEN NAME <b>MAGGIE COPPER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-07-9452</b>			
17. INFORMANT <b>Lester Adams - McDaniel, Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension arteriosclerosis</b> DUE TO (c) <b>10 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1961</b> to <b>Dec 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 13, 1961</b> , and that death occurred at <b>11:50 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>GUY M REESER</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>GUY M REESER</b>				22d. ADDRESS <b>TILGHMAN Md</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-17-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Richards Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Easton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Bechell - Easton, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 EASTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAN HOSPITAL</u>		d. STREET ADDRESS <u>412 S. WASHINGTON</u>	
3. NAME OF DECEASED (Type or print) First <u>BERNHARD</u> Middle <u>AIRY</u> Last <u>BLOCK</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 1 1898</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BERNHARD A. BLOCK</u>		14. MOTHER'S MAIDEN NAME <u>ABBEY EUGENIA KNELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW#1</u>		16. SOCIAL SECURITY NO. <u>215-091141</u>	
17. INFORMANT <u>MRS. GLADYS S. BLOCK</u>		Address <u>412 S. WASHINGTON, EASTON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>1:03 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE		25c. DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

14464

**CERTIFICATE OF DEATH**

14431

1. PLACE OF DEATH a. COUNTY <b>Talbot MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Centerville Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>"Brewersville" 17X-2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sandy Bonds</b>		4. DATE OF DEATH Month Day Year <b>12 15 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>? ? 1890</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Former Head of Garden</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Brewersville 206 Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sandy Bonds</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Gassaway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-0913</b>	
17. INFORMANT <b>Walter S Bonds Centerville Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular disease</b> (c) <b>Cardiovascular disease</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Suprapubic Prostatectomy P.O. B.K.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-12-1961</b> to <b>12-15-1961</b> , that (I) (we) last saw the deceased alive on <b>12-15-1961</b> , and that death occurred at <b>10:30</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>John N. Robinson</b>		22b. DATE SIGNED <b>12-19-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John N. Robinson</b>		22d. ADDRESS <b>M. D. Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 18-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brewersville (Private)</b>		23d. LOCATION (City, town or county) (State) <b>Rural Centerville Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Butler, Jr. Centerville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 26 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



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may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE BOARD OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

14465

14432

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>18 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u> <u>17X-2</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis</u> <u>Henry</u> <u>Booth</u>				4. DATE OF DEATH Month Day Year <u>Dec</u> <u>10</u> <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-10-03</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Louis H. Booth, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Annie Botts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>664-09-8884</u>		17. INFORMANT <u>Mrs. Thelma Booth</u> Address <u>Grasonville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus</u> DUE TO <u>150X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>11/22-1961</u> to <u>12/10-1961</u> , that (I) (we) last saw the deceased alive on <u>12/9-1961</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Arthur B. Cecil Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-19-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur B. Cecil Jr.</u>				22d. ADDRESS <u>Easton, Maryland</u>		22e. DATE <u>12-19-61</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BRYANS Cem.</u>		23d. LOCATION (City, town, or county) <u>Grasonville, Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashwell</u> ADDRESS <u>Easton Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur B. Cecil</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14433

14466

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELY</b>			
c. LENGTH OF STAY IN TB <b>2 hr</b>				d. STREET ADDRESS <b>NONE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTON MEMORIAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Curtis NATHANIEL Boyce</b>				4. DATE OF DEATH Month Day Year <b>Dec 23 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 14, 1961</b>	
9. AGE (in years last birthday) yrs. <b>3</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Boyce</b>		14. MOTHER'S MAIDEN NAME <b>Alease Handy</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James Boyce Ridgely Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute purulent meningitis</b> 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-25-61</b> to <b>12-25-61</b> , that (I) (we) last saw the deceased alive on <b>12-25-61</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>E.C.H. Schmidt</b>				22b. DATE SIGNED <b>24 Dec 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>E.C.H. Schmidt</b>				22d. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Flowers Burial Ground</b>		23d. LOCATION (City, town or county) (State) <b>Ridgely, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Boulais</b>				25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>							

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STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

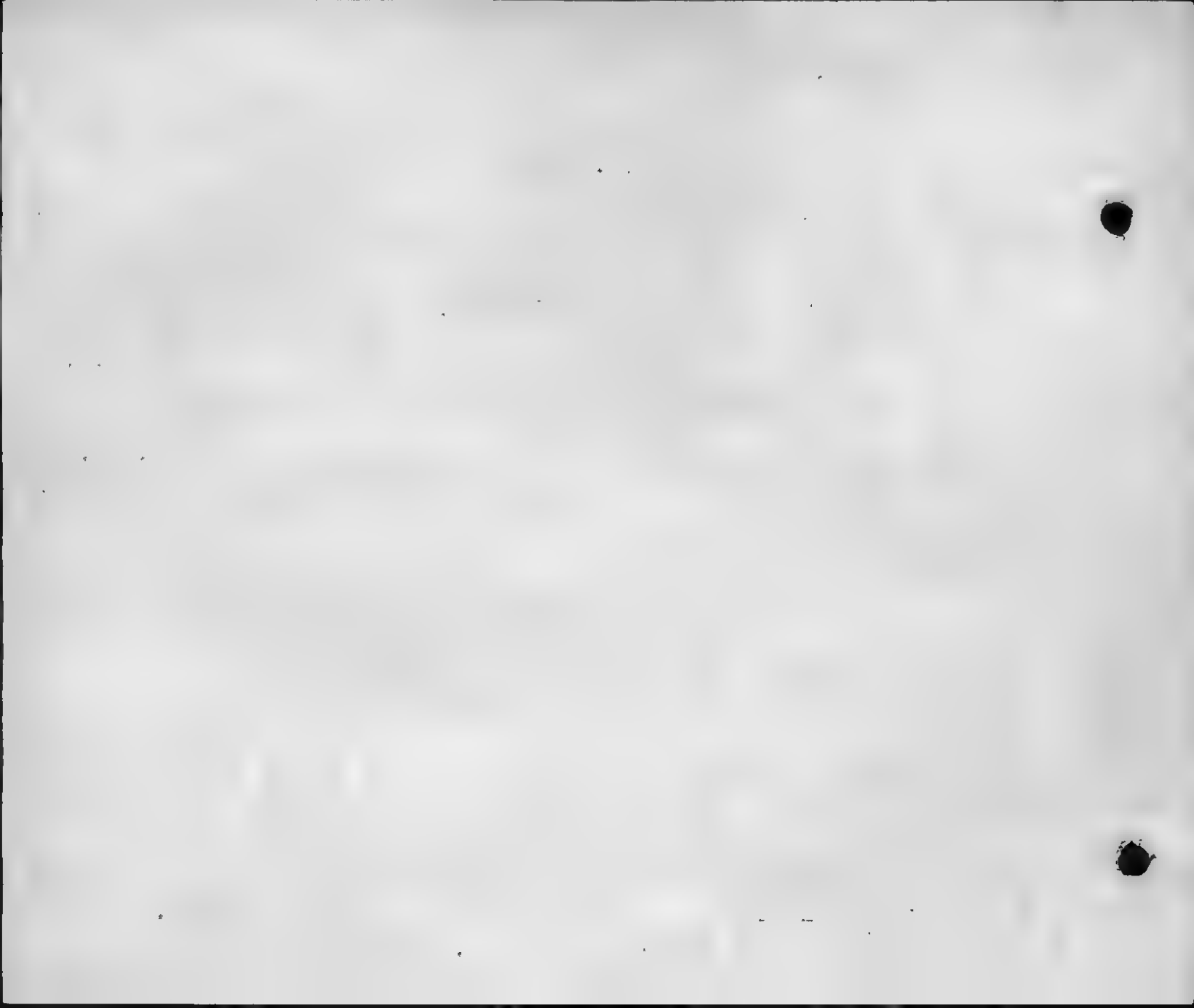
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
14467													
14434													
1. PLACE OF DEATH a. COUNTY <b>Talbot</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Queen Ann</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Price</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Easton Memorial Hospital</b>				d. STREET ADDRESS <b>None</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charnal Louise Brooks</b>				4. DATE OF DEATH Month Day Year <b>December 9 19 61</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 20, 1961</b>		9. AGE (In years last birthday) Yrs. <b>5</b> Months <b>5</b> Days <b>19</b> Hours <b></b> Min. <b></b>		10. IF UNDER 1 YEAR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sammie Roberts</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Louise Brooks</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>				17. INFORMANT <b>Carrie Ridgeway</b>				Address <b>Price, Md.</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Belatous Broncho-Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b>												INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) <b></b>		(State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12-9-1961</b> to <b>12-9-1961</b> , that (I) (we) last saw the deceased alive on <b>12-9-1961</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Robert H. Wright</b>				22b. DATE SIGNED <b>12-11-61</b>									
22c. PHYSICIAN'S NAME (Type) <b>ROBERT H. WRIGHT MD</b>				22d. ADDRESS <b>Greensboro Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hope</b>		23d. LOCATION (City, town or county) <b>near Price, Md.</b>				(State) <b></b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Boulais Jr.</b>				ADDRESS <b>Greensboro, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 12 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Catherine L. Hanna</b>			

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. No 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

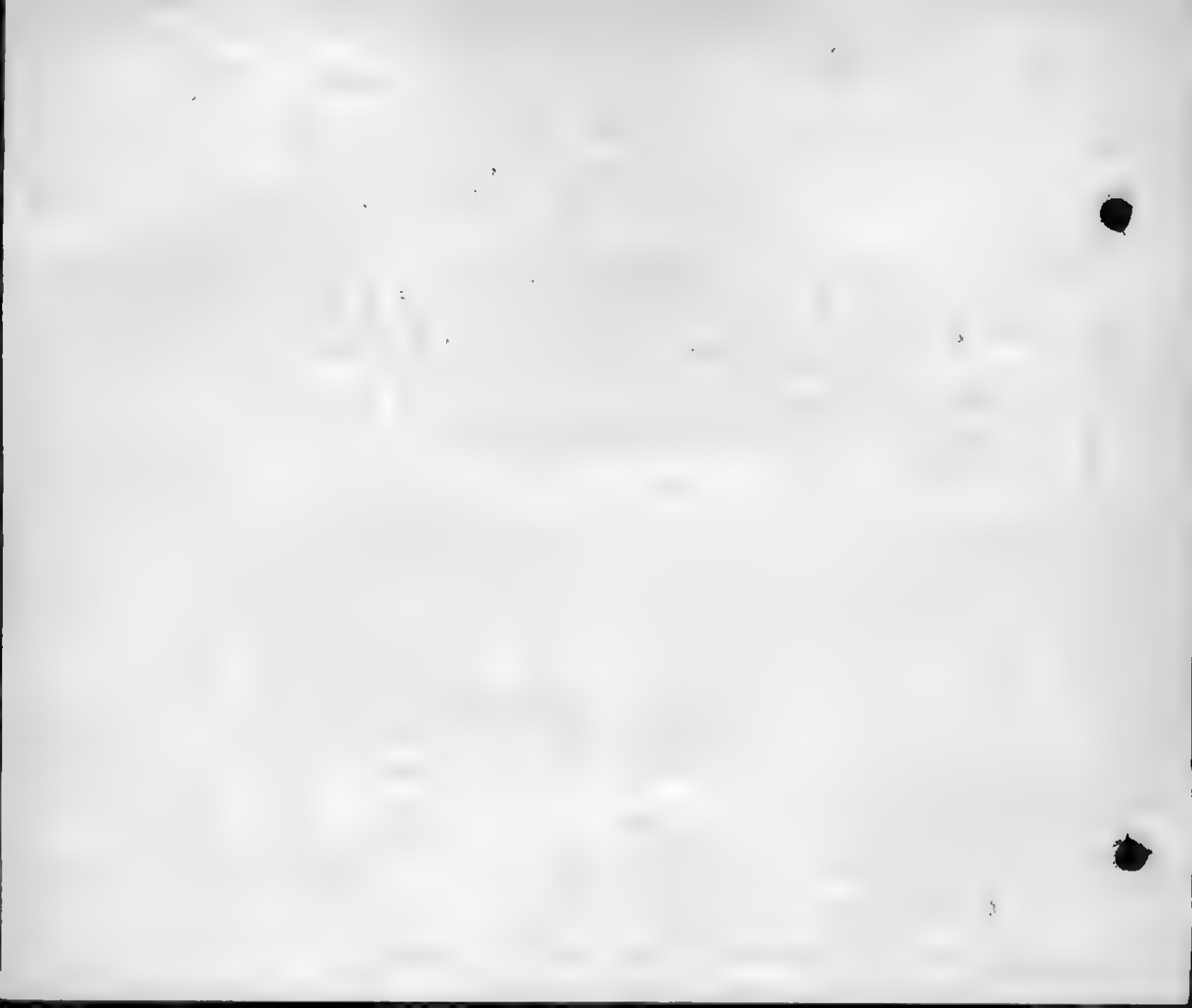
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14468

14435

<b>1. PLACE OF DEATH</b> a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>EASTON Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Denton</u> d. STREET ADDRESS <u>511 High Street</u> e. 15' RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>SARAH Elizabeth Brown</u>		<b>4. DATE OF DEATH</b> December 17, 1961		<b>5. SEX</b> <u>Fe</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 14, 1919</u>		<b>9. AGE</b> (In years last birthday) <u>42</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>John Ringgold</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Bertha Boyce</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, or unknown) <u>NO</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>220-03-4420</u>			
<b>17. INFORMANT</b> <u>PAUL Brown</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right breast</u> Conditions, if any, which gave rise to immediate cause (b) <u>with widespread metastases</u> (c) <u>170X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>				<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>				<b>21. I certify that</b> (I) (this hospital) attended the deceased from <u>  </u> 19 <u>  </u> to <u>  </u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that death occurred at <u>  </u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>E. C. H. Schmidt</u>				<b>22b. DATE</b> <u>18 Dec 1961</u>				<b>22c. PHYSICIAN'S NAME</b> (Type) <u>E. C. H. Schmidt</u>				<b>22d. ADDRESS</b> <u>Easton, Maryland</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>Dec. 23, 1961</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sandtown Cem.</u>				<b>23d. LOCATION</b> (City, town or county) <u>Hillsboro, Md.</u> (State) <u>  </u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James E. Easton</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 21 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. To 4 may be retained by the hospital or attending physician.

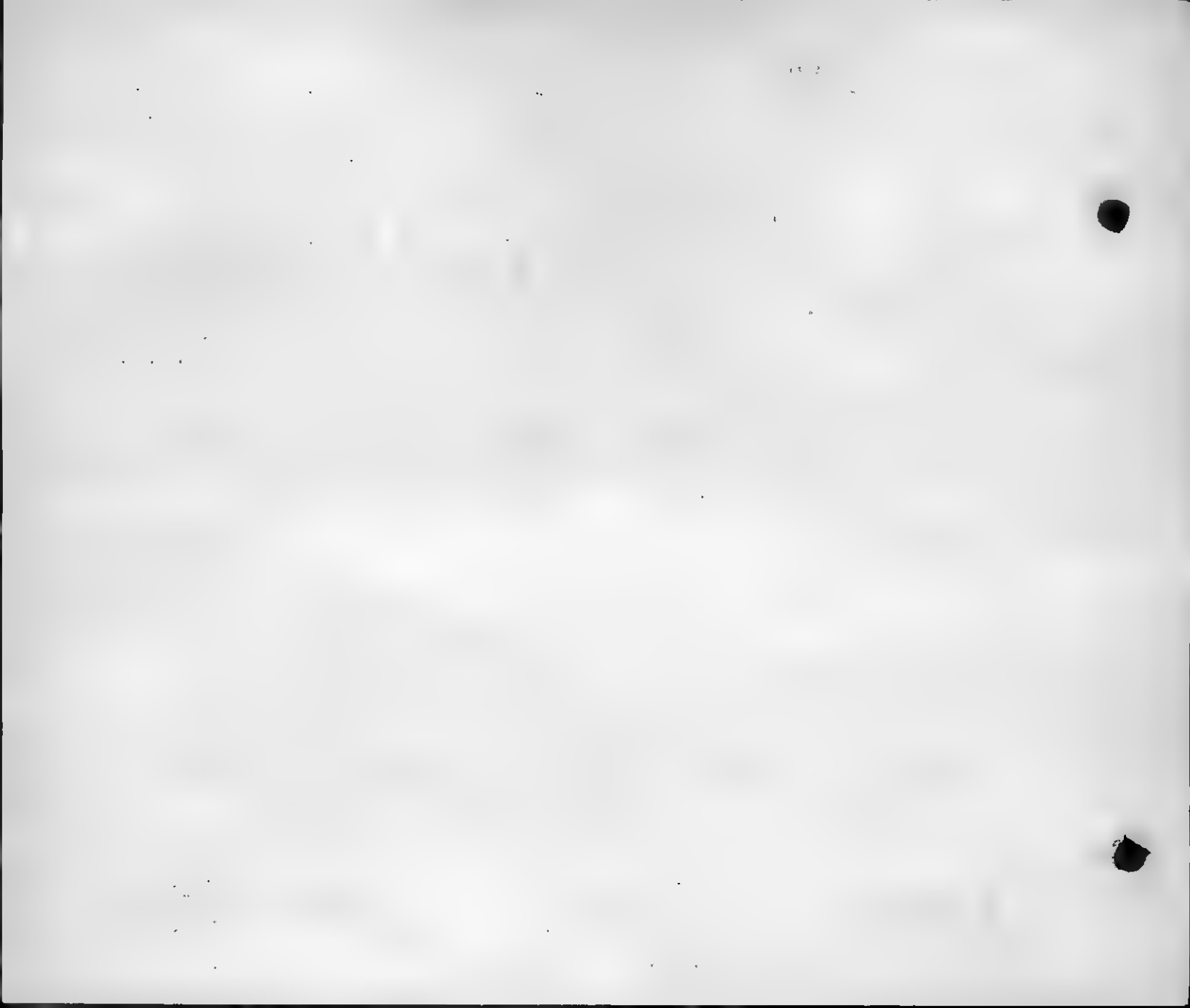
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

<p><b>1. PLACE OF DEATH</b> a. COUNTY <u>ALBON</u> <b>MARYLAND</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u></p> <p>c. LENGTH OF STAY IN MD</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hosp.</u></p>		<p><b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission)</p> <p>e. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u></p> <p>d. STREET ADDRESS <u>None</u></p>	
<p><b>3. NAME OF DECEASED</b> (Type or print) <u>Sue</u> First <u>Burke</u> Middle <u>Burke</u> Last</p>		<p><b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>17</u> Year <u>1961</u></p>	
<p><b>5. SEX</b> <u>Female</u></p>		<p><b>6. COLOR OR RACE</b> <u>Col.</u></p>	
<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <u>6-12-1889</u></p>	
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u></p>	
<p><b>11. BIRTHPLACE</b> (County &amp; State, or foreign country) <u>Maryland</u></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u></p>	
<p><b>13. FATHER'S NAME</b> <u>Martin Hicks</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <u>Mandy Conish</u></p>	
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>		<p><b>16. SOCIAL SECURITY NO.</b> <u>None</u></p>	
<p><b>17. INFORMANT</b> <u>Rosie Johns Ridgely, Maryland</u></p>		<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>(a) IMMEDIATE CAUSE (a) <u>6000</u> DUE TO <u>Heart</u></p> <p>(b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <u>Chronic pyelonephritis</u></p> <p>(c)</p>	
<p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</p>			
<p><b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p><b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u></p>		<p><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	
<p><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)</p>		<p><b>20f. (City or town) (County) (State)</b></p>	
<p><b>21. I certify that (I) (this hospital) attended the deceased from <u>12/4/61</u> to <u>12/17/61</u>, that (I) (we) last saw the deceased alive on <u>17 Dec 1961</u>, and that death occurred at <u>17 Dec 1961</u> from the causes and on the date stated above.</b></p>			
<p><b>22a. SIGNATURE</b> <u>Thurston Harrison</u></p>		<p><b>22b. DATE SIGNED</b> <u>19 Dec 61</u></p>	
<p><b>22c. PHYSICIAN'S NAME</b> (Type) <u>THURSTON HARRISON</u></p>		<p><b>22d. ADDRESS</b> <u>Easton, Maryland</u></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u></p>		<p><b>23b. DATE THEREOF</b> <u>12-20-61</u></p>	
<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cokers</u></p>		<p><b>23d. LOCATION</b> (City, town or county) (State) <u>Greensboro, Maryland</u></p>	
<p><b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J.E. Boulois Greensboro, Md.</u></p>		<p><b>25a. REC'D BY REGISTRAR</b> <u>DEC 22 61</u></p>	
<p><b>25b. REGISTRAR'S SIGNATURE</b> <u>Carol S. Frank</u></p>		<p><b>25c. DATE</b></p>	

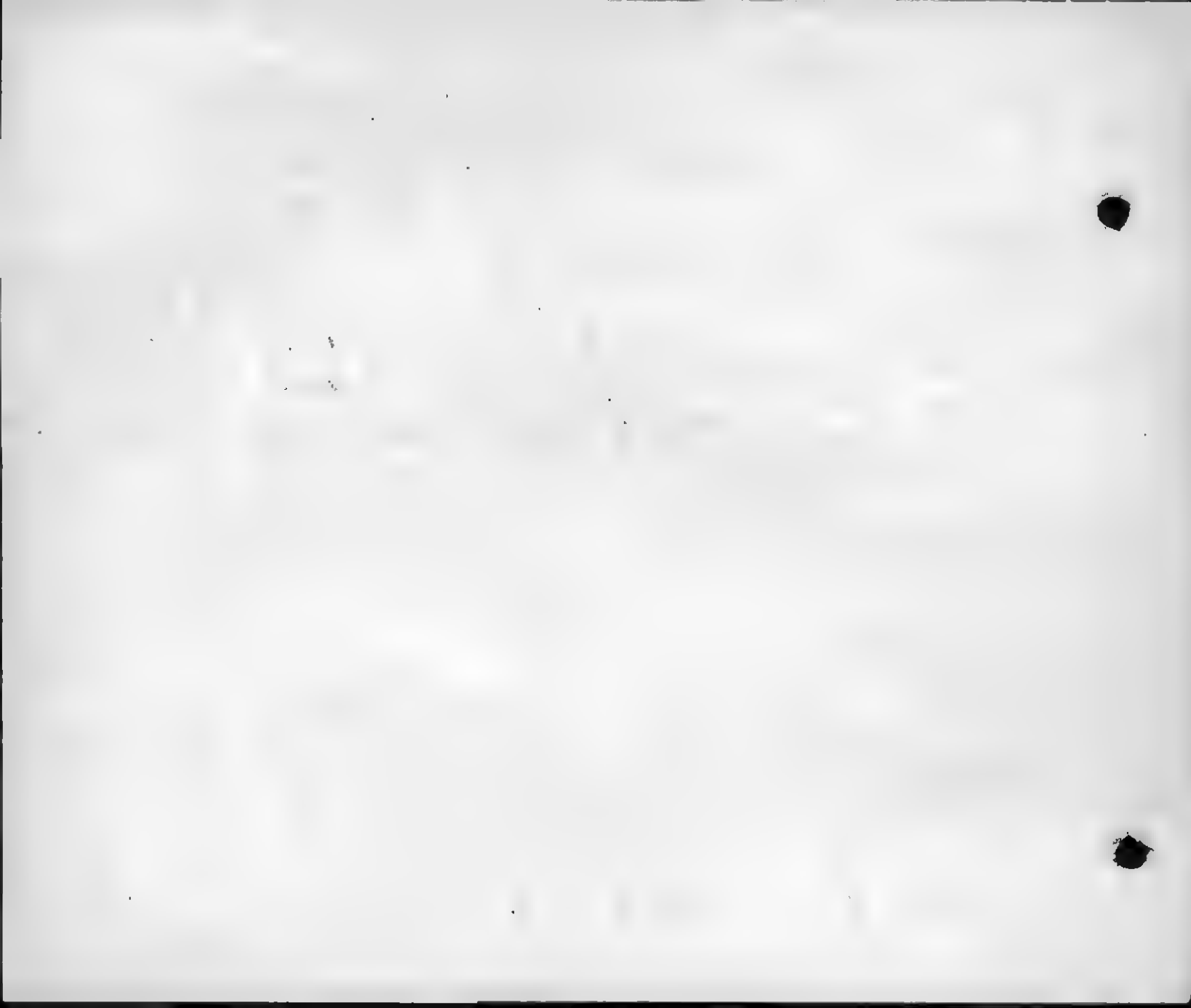


may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14470  
14437  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X OXFORD</b>	
		d. STREET ADDRESS <b>1 Tilghman</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AROLYN</b> Middle <b>LEE</b> Last <b>BUTLER</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1961</b>
9. AGE (In years lost birthday) <b>3 1/2</b> yrs.		10. IF UNDER 1 YEAR: Months <b>3</b> Days <b>18</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EZKIEL BARNES</b>		14. MOTHER'S M maiden name <b>MARYLAND BUTLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MARYLAND BUTLER</b>		Address <b>Oxford, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malnutrition, Prematurity</b> <b>755X</b> DUE TO (b) <b>Haulijs + Cleft Palate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks birth -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-18</b> 19 <b>61</b> to <b>11-16</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>11-16</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>John E. Baybutt</b> M.D.		22b. DATE SIGNED <b>12-14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John E. Baybutt M.D.</b>		22d. ADDRESS <b>205 Earle Ave EASTON</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec. 8 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>STREAMERSVILLE Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>OXFORD, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James C. Cusick</b>		25a. REC'D BY REGISTRAR <b>DEC 18 '61</b>	
ADDRESS <b>EASTON, Md.</b>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

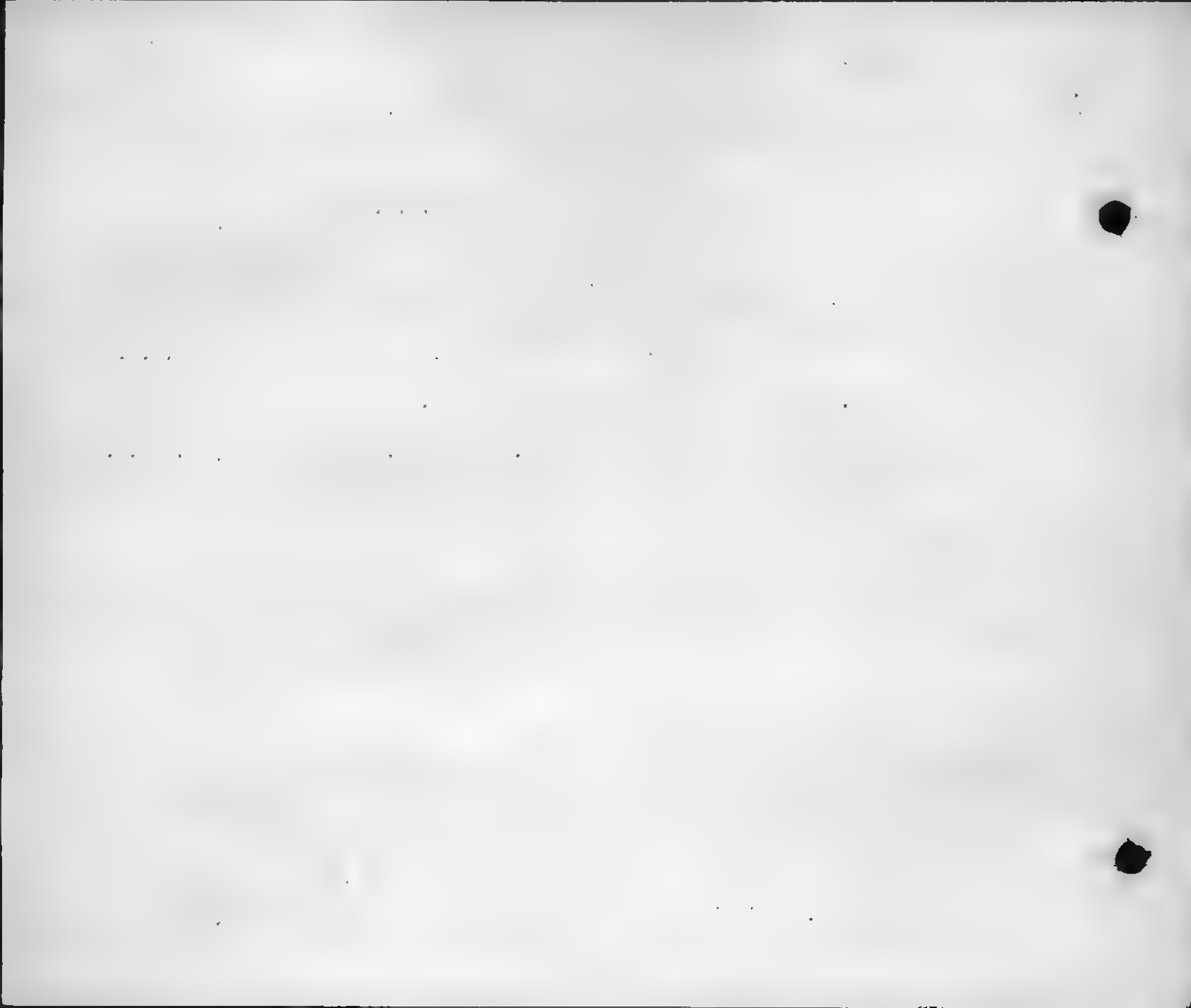
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14471

14438

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>R.F.D. #1</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Thomas Michael Cole</u>		<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1958</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>17</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Easton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willard T. Cole</u>		14. MOTHER'S MAIDEN NAME <u>Helen L. Nimmo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Willard T. Cole, Easton, Md., R.F.D.</u>		Address <u>R.F.D.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Conventional heart disease</u> Conditions if any, which gave rise to immediate cause (b) <u>754.5</u> (c), stating the underlying cause last. DUE TO <u>754.5</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Easton, Maryland</u>		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 19... to 19... that (I) (we) last saw the deceased alive on 19... and that death occurred at 19... from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>E.C.H. Schmidt</u>		<b>22b. DATE SIGNED</b> <u>18 Dec 1961</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>E.C.H. Schmidt</u>		<b>22d. ADDRESS</b> <u>Easton, Maryland</u>	
<b>23a. BURIAL CREMATION REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Dec. 20, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Junior Order Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Preston, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. J. Fraughton</u>		<b>24. ADDRESS</b> <u>Edwardsburg, Maryland</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>DEC 22 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles L. Hanna</u>	





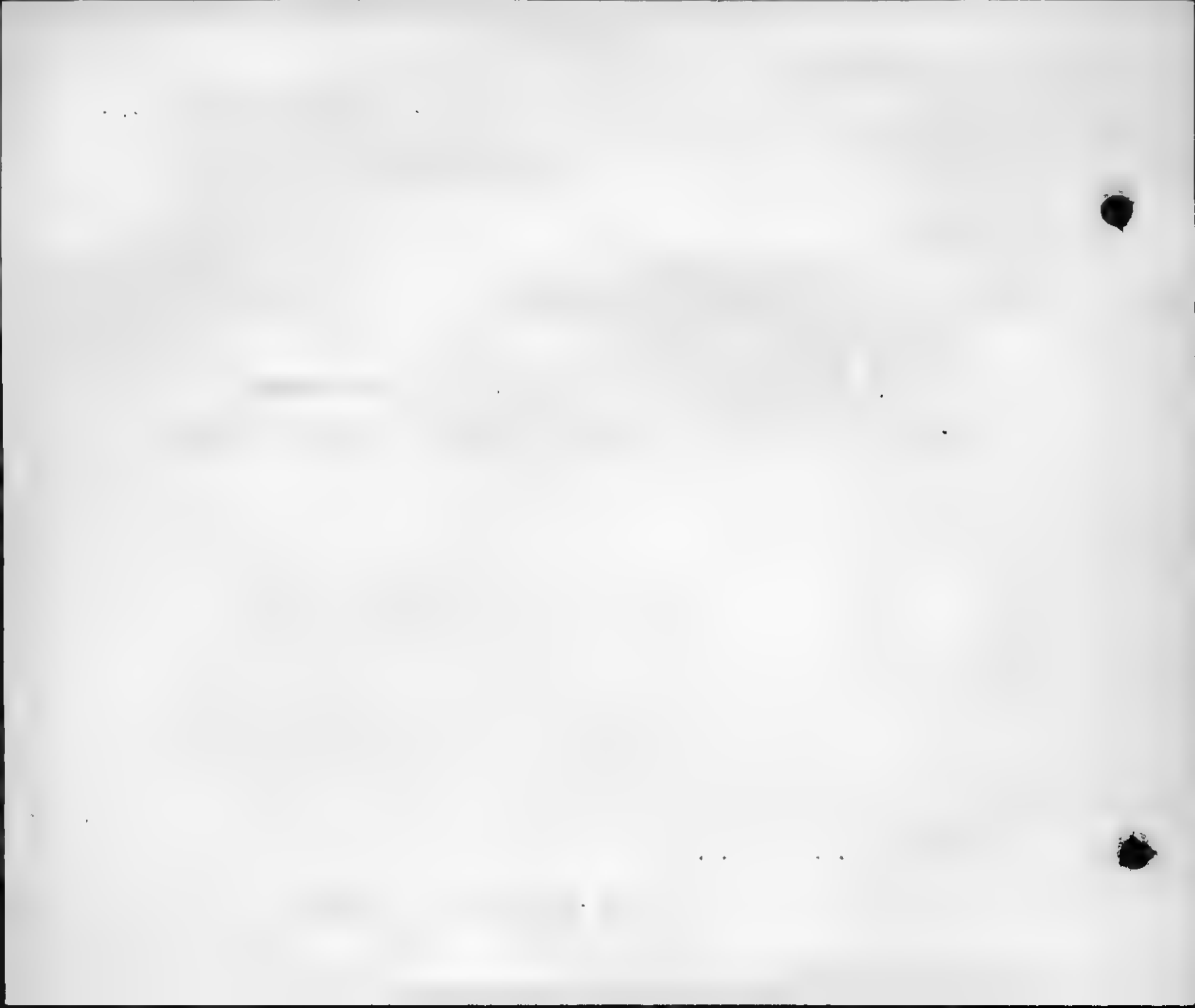
1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 2 - Easton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Chapel</b>	
3. NAME OF DECEASED (Type or print) <b>WillIAM</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1878</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>tenant-farmer</b>	9c. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>tenant-farmer</b>	10c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
11. FATHER'S NAME <b>James Collins</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Collins</b>		14. MOTHER'S MAIDEN NAME <b>Fannie MARTIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Elizabeth Collins - Rural-Easton</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxiation</b>			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>House burned down</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12-24</b> p.m. <b>1961</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) (County) (State) <b>Easton Talbot Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Louis Welty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WELTY</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Dec 23, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Chapel</b>		22d. LOCATION (City, town, or country) (State) <b>Easton - Rural Md.</b>	
23. FUNERAL DIRECTOR <b>James Beasly - Easton, Md</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



1  
14473  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN lb <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorian Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sadie MARY Cryer</u>				4. DATE OF DEATH Month Day Year <u>December 6 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 21, 1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>S. Frank Merrick</u>				14. MOTHER'S M maiden name <u>Sellie Leonard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>220-34-7587</u>		17. INFORMANT <u>Patton Cryer</u> Address <u>Suppe Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Ovary</u> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 12/6</u> to <u>12/6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>61</u> , and that death occurred on <u>12/6</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>December 6, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>P. E. Cox, M.D.</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, or other disposal <u>Burial</u>		23b. DATE THEREOF <u>Dec. 8, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		23d. LOCATION (City, town, or county) <u>Easton Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice F. Neumann &amp; Son</u> ADDRESS <u>Easton, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14474

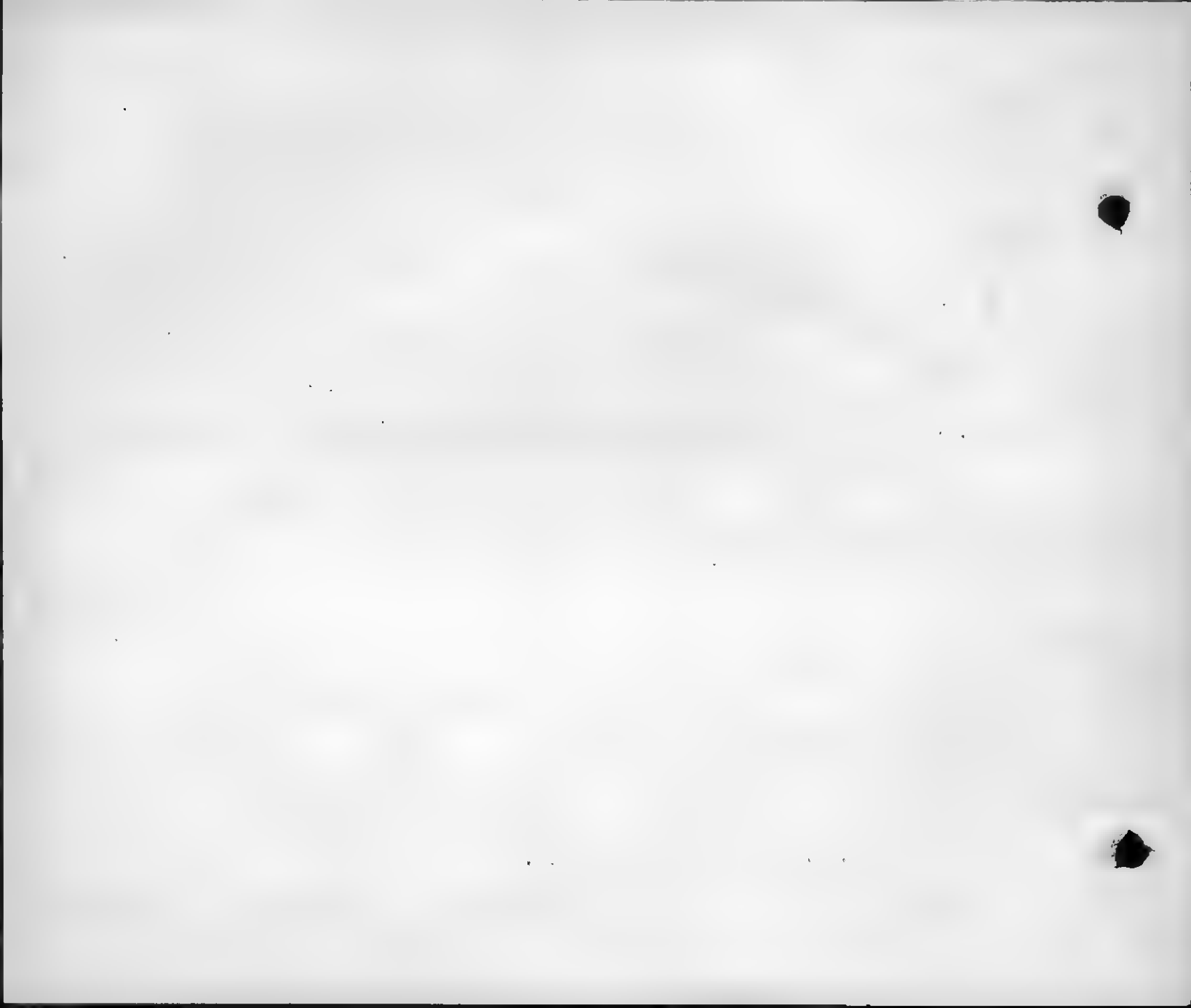
14441

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial Hosp</u>		d. STREET ADDRESS <u>Centreville</u>	
3. NAME OF DECEASED (Type or print) <u>EVA</u> First <u>DAVIS</u> Middle Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1911</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harvey Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Gertude Griffin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>William Davis Centreville, Md.</u> Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Peritonitis</u> DUE TO (c) <u>Mesenteric thrombosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive <u>at 5:30 P.M.</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>E.C.H. Schmidt</u> M.D.		22b. DATE SIGNED <u>Jan 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN. 3, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Carmichael Cem</u>		23d. LOCATION (City, town or county) (State) <u>Queens town Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Warner</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>Easton Md -</u>		DATE <u>JAN 4 '62</u>	









1. PLACE OF DEATH  
a. COUNTY **TALBOT**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **MD** b. COUNTY **Dor**

3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
**Easton**

4. LENGTH OF STAY IN 1b  
**6 days**

5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
**East New Market**

6. STREET ADDRESS

7. IS RESIDENCE ON A FARM? YES ☐ NO ☒

8. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  
**Easton Memorial Hospital**

9. NAME OF DECEASED (Type or print)  
First **David** Middle **Leon** Last **DENNARD**

10. DATE OF DEATH  
Month **Dec** Day **21** Year **1961**

11. SEX **Male**

12. COLOR OR RACE **Colored**

13. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

14. DATE OF BIRTH  
**3/11/1911**

15. AGE (In years last birthday) **50** IF UNDER 1 YEAR Months **2** Days **20** IF UNDER 24 HRS. Hours **20** Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (County & State, or foreign country)  
**MD**

19. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

20. FATHER'S NAME

21. MOTHER'S MAIDEN NAME  
**G. Herbert Stephens**

22. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

23. SOCIAL SECURITY NO

24. INFORMANT  
**John L. Dennard, East New Market**

25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Be-lateral pneumonia**  
DUE TO (b)  
DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
**Myocardial infarction**

26. INTERVAL BETWEEN ONSET AND DEATH

27. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

28. MEDICAL CERTIFICATION  
28a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

28b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

28c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m. 19

28d. INJURY OCCURRED While at work ☐ Not While at work ☐

28e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

28f. (City or town) (County) (State)

29. I certify that (I) (this hospital) attended the deceased from..... 19....., to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... 19....., from the causes and on the date stated above.

30. SIGNATURE  
**F. C. H. Schmidt** M.D.

31. PHYSICIAN'S NAME (Type)  
**F. C. H. Schmidt**

32. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

33. ADDRESS  
**Easton, Maryland**

34. DATE SIGNED  
**Dec 22 1961**

35. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

36. DATE THEREOF  
**12/22/61**

37. NAME OF CEMETERY OR CREMATORY  
**East New Market**

38. LOCATION (City, town or county) (State)  
**East New Market Maryland**

39. FUNERAL DIRECTOR'S SIGNATURE  
**William H. Fennell**

40. ADDRESS  
**William H. Fennell Funeral Home**

41. REC'D BY REGISTRAR  
**DEC 27 '61**

42. REGISTRAR'S SIGNATURE  
**Arthur S. Hines**

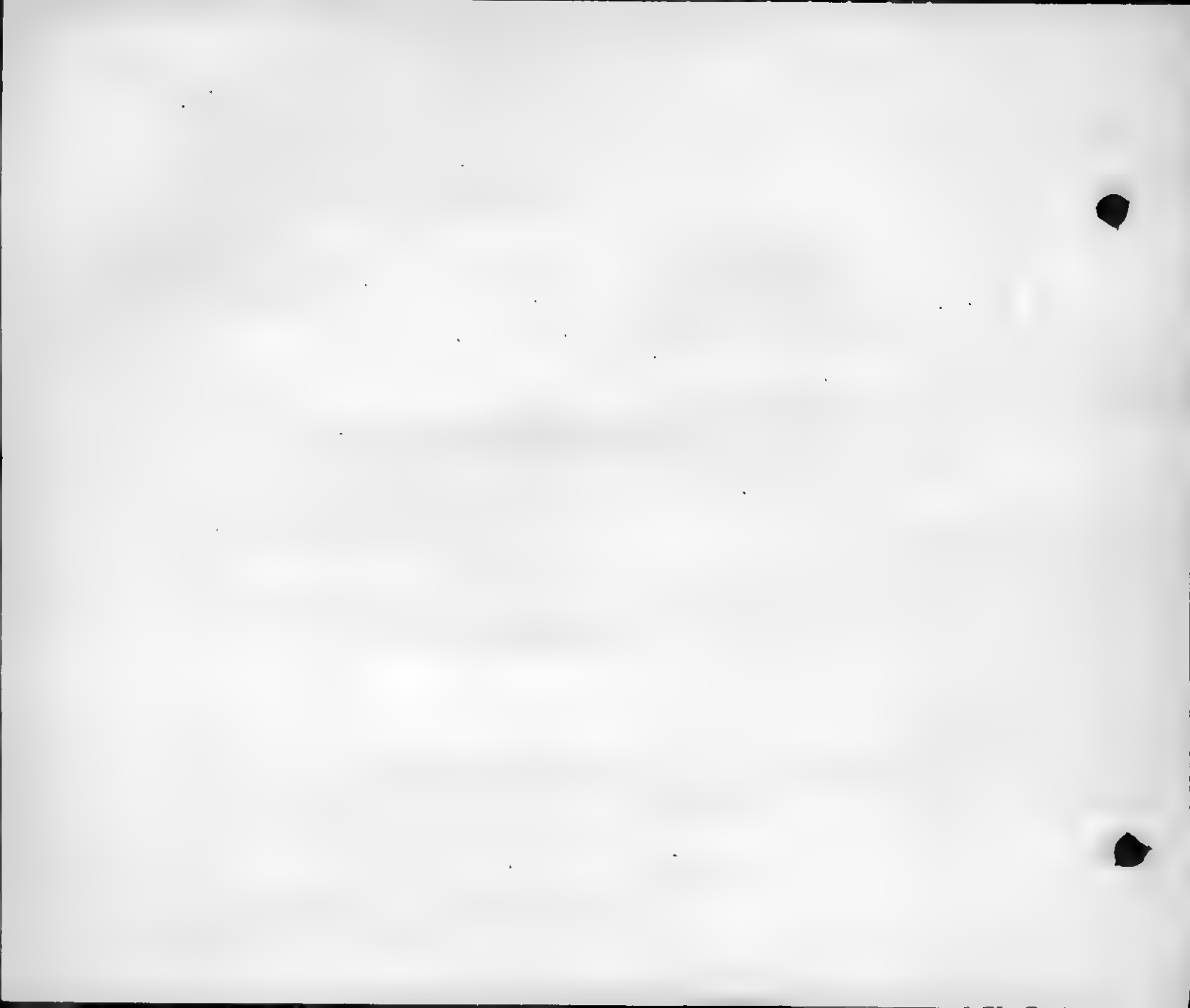


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14444

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>DoA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>			
f. STREET ADDRESS <b>401 Hanson Lk.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>T</b> Last <b>Dwyden</b>				4. DATE OF DEATH <b>Dec 13 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 24, 1907</b>	
9. AGE (In years last birthday) <b>54 yrs</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b> Hours <b>13</b> Min <b>13</b>		11. IF UNDER 24 HRS Months <b>3</b> Days <b>4</b> Hours <b>13</b> Min <b>13</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EX. VICE PRES.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>J. McKENNY (FEED) WILLIS &amp; SON</b>			
11. BIRTHPLACE (State or foreign country) <b>New York City</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Robert W. Dwyden</b>				14. MOTHER'S MAIDEN NAME <b>Florence Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-01-1628</b>			
17. INFORMANT <b>Robert Dwyden</b> Address <b>Easton Md.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Death due to (1) Possible Coronary Artery (2) Aortic Myocarditis (3) Cause Unknown</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12-7</b> to <b>12-13</b> , 19 <b>61</b> , that (I) <del>was</del> lost saw the deceased alive on <b>12-13</b> , 19 <b>61</b> , and that death occurred on <b>4-13</b> from the causes and on the date stated above							
22a. SIGNATURE <b>William L. Winters</b> M.D.				22b. DATE SIGNED <b>12-15-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM L. WINTERS</b>				22d. ADDRESS <b>210 E DOVER EASTON MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>				23b. DATE THEREOF <b>DEC. 18, 1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>				23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Neumann</b> ADDRESS <b>501 Easton, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 18 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Wm S. Fina</b>							

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. The funeral director, may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 4 hours of death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME  
5M 7/59

(M)

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
TALBOT				Maryland			
EASTON				Talbot			
Memorial Hospital				Trappe			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
Harry EDGAR Faulkner				Dec 29 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH	
Male		White		NEVER MARRIED		May 13, 1892	
				WIDOWED		69 yrs.	
				DIVORCED		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Antenneman				Maryland			
13. FATHER'S NAME				14. MOTHER'S M maiden name			
Edward Faulkner				Lillian Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
no				218-24-2781			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. WAS AUTOPSY PERFORMED?			
PART I DEATH WAS CAUSED BY:				YES <input type="checkbox"/> NO <input type="checkbox"/>			
(a) IMMEDIATE CAUSE				INTERVAL BETWEEN ONSET AND DEATH			
1. Cerebral Hemorrhage							
2. HCD							
3. DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO							
(c) DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
19				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
21a. SIGNATURE				21b. DATE SIGNED			
Loris O'Malley				17-30-61			
21c. EXAMINER'S NAME (Type)				21d. DEPUTY MEDICAL EXAMINER			
INF LTV				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan 2, 1962		Upper Bamberg		Trappe (Rural) Md.	
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR			
Maurice E. Newnam - Talbot, Md.				JAN 3 '62			
				24b. REGISTRAR'S SIGNATURE			
				E. L. H. H. H.			



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

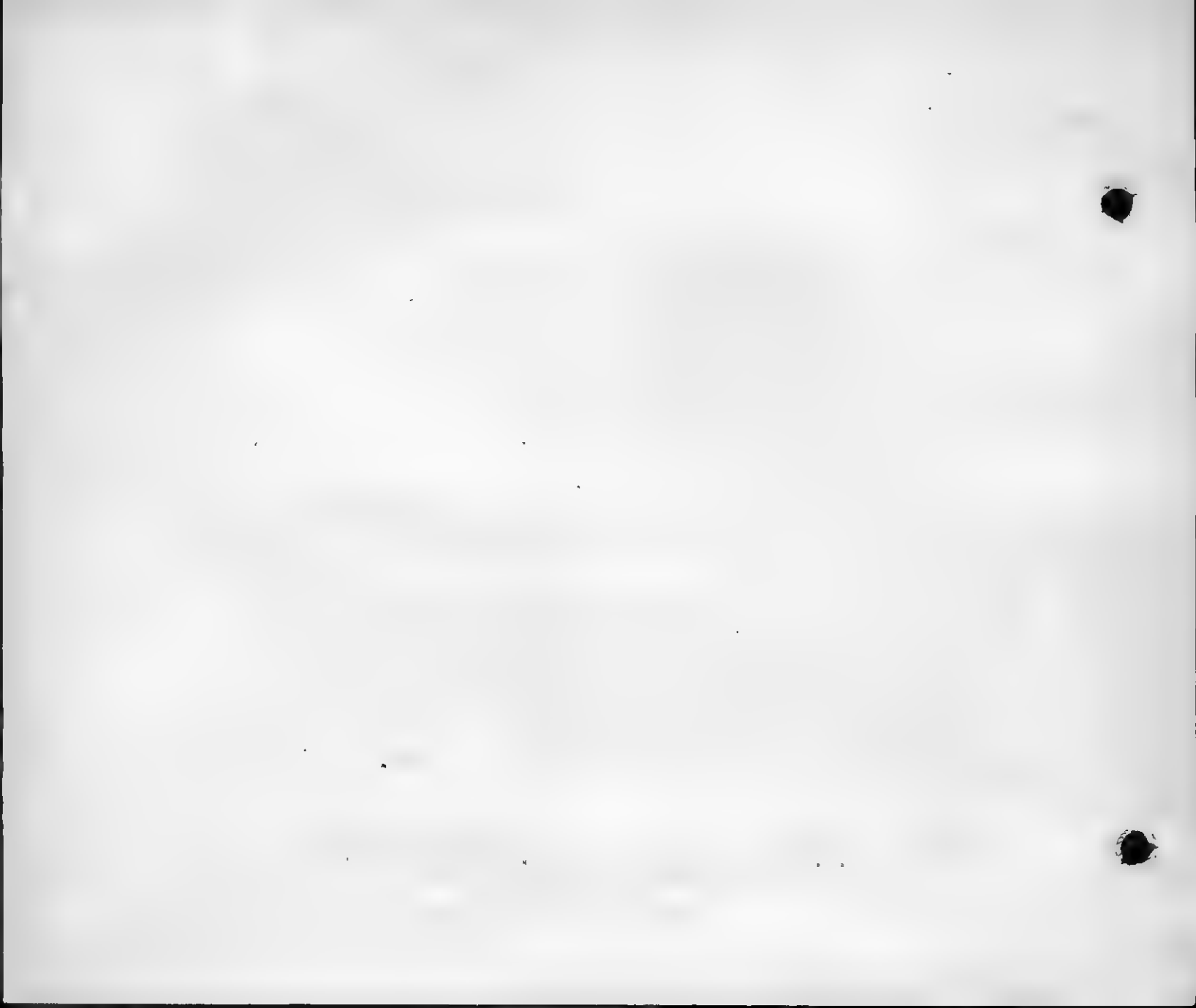
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15M 9/59

14479

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14446

1 PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>15 min.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ORR</i> Middle <i>Fisher</i> Last <i>JR.</i>		4. DATE OF DEATH Month <i>December</i> Day <i>1</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 25, 1893</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retail merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>grocery</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Orr Fisher</i>		14. MOTHER'S MAIDEN NAME <i>Annie Vagg</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO <i>215 20 1378</i>	
17. INFORMANT <i>Wm. O. Fisher, Easton, RD, Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO (c) <i>Diabetes mellitus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 12-1-1961</i> to <i>12-1-1961</i> , that (I) (we) last saw the deceased alive on <i>12-1-1961</i> and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>P. E. Cox</i>		22b. DATE SIGNED <i>12/2/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>P. E. Cox</i>		22d. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMAT., OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/5/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Easton, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. Frampton Carroll</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 6 '61</i>	
ADDRESS <i>Easton, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>C. L. S. Thomas</i>	



may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14480

14447

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cordova</b>		c. LENGTH OF STAY IN 1b <b>30 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>Carroll</b> Last <b>Fisher</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1875</b>
9. AGE (In years last birthday) <b>86 yrs</b>		10. IF UNDER 1 YEAR Months <b>18</b> Days <b>29</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Carroll</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Morris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mr. John C. North, Easton, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio sclerosis</b> DUE TO <b>18 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 18, 1958</b> to <b>Dec 29, 1961</b> , that (I) (we) lost saw the deceased alive on <b>Dec 28, 1961</b> , and that death occurred <b>11:55 A</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>E. Paul Knotts</b>		22b. DATE SIGNED <b>Nov. 18, 1958</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Paul Knotts, M.D.</b>		22d. ADDRESS <b>Denton, Maryland</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/2/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Frazier</b>		25a. REC'D BY REGISTRAR <b>Jan 3 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Jan 3, 1962</b>		25c. DATE	

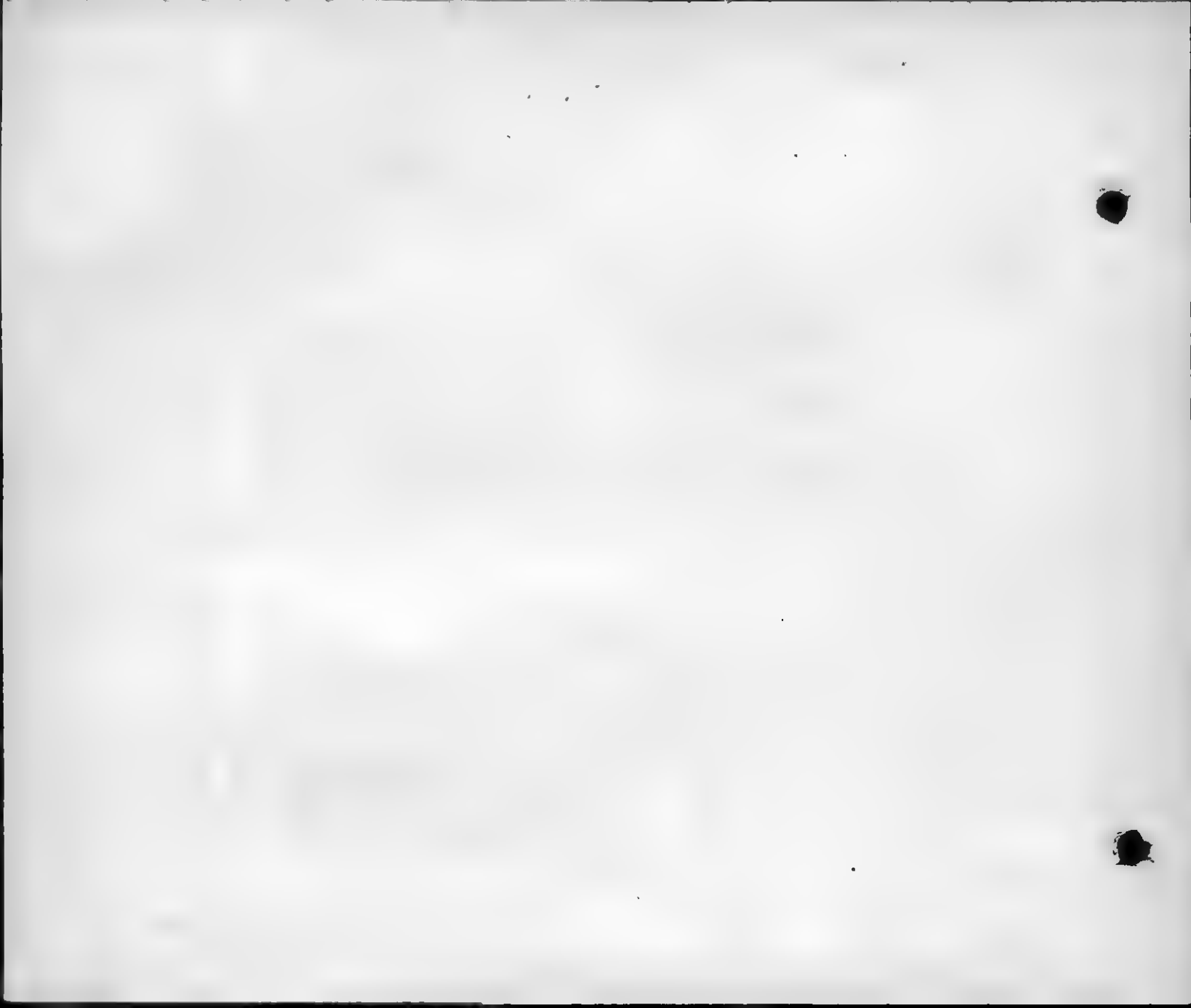


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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

Items 2, 3, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 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1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1420, 1421, 1422, 1423, 1424, 1425, 1426, 1427, 1428, 1429, 1430, 1431, 1432, 1433, 1434, 1435, 1436, 1437, 1438, 1439, 1440, 1441, 1442, 1443, 1444, 1445, 1446, 1447, 1448, 1449, 1450, 1451, 1452, 1453, 1454, 1455, 1456, 1457, 1458, 1459, 1460, 1461, 1462, 1463, 1464, 1465, 1466, 1467, 1468, 1469, 1470, 1471, 1472, 1473, 1474, 1475, 1476, 1477, 1478, 1479, 1480, 1481, 1482, 1483, 1484, 1485, 1486, 1487, 1488, 1489, 1490, 1491, 1492, 1493, 1494, 1495, 1496, 1497, 1498, 1499, 1500, 1501, 1502, 1503, 1504, 1505, 1506, 1507, 1508, 1509, 1510, 1511, 1512, 1513, 1514, 1515, 1516, 1517, 1518, 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1685, 1686, 1687, 1688, 1689, 1690, 1691, 1692, 1693, 1694, 1695, 1696, 1697, 1698, 1699, 1700, 1701, 1702, 1703, 1704, 1705, 1706, 1707, 1708, 1709, 1710, 1711, 1712, 1713, 1714, 1715, 1716, 1717, 1718, 1719, 1720, 1721, 1722, 1723, 1724, 1725, 1726, 1727, 1728, 1729, 1730, 1731, 1732, 1733, 1734, 1735, 1736, 1737, 1738, 1739, 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1747, 1748, 1749, 1750, 1751, 1752, 1753, 1754, 1755, 1756, 1757, 1758, 1759, 1760, 1761, 1762, 1763, 1764, 1765, 1766, 1767, 1768, 1769, 1770, 1771, 1772, 1773, 1774, 1775, 1776, 1777, 1778, 1779, 1780, 1781, 1782, 1783, 1784, 1785, 1786, 1787, 1788, 1789, 1790, 1791, 1792, 1793, 1794, 1795, 1796, 1797, 1798, 1799, 1800, 1801, 1802, 1803, 1804, 1805, 1806, 1807, 1808, 1809, 1810, 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, 1820, 1821, 1822, 1823, 1824, 1825, 1826, 1827, 1828, 1829, 1830, 1831, 1832, 1833, 1834, 1835, 1836, 1837, 1838, 1839, 1840, 1841, 1842, 1843, 1844, 1845, 1846, 1847, 1848, 1849, 1850, 1851, 1852, 1853, 1854, 1855, 1856, 1857, 1858, 1859, 1860, 1861, 1862, 1863, 1864, 1865, 1866, 1867, 1868, 1869, 1870, 1871, 1872, 1873, 1874, 1875, 1876, 1877, 1878, 1879, 1880, 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1888, 1889, 1890, 1891, 1892, 1893, 1894, 1895, 1896, 1897, 1898, 1899, 1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189





MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14482

14449

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hospital</b>		d. STREET ADDRESS <b>Chester</b>	
3. NAME OF DECEASED (Type or print) <b>Willie</b> First Middle Last <b>GREEN.</b>		4. DATE OF DEATH Month <b>12</b> - Day <b>12</b> Year <b>1961</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>About 70</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-2833</b>	
17. INFORMANT Address <b>Mrs. Hilde Henderson, Chester, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, etiology not determined</b> DUE TO <b>1-13X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>DO NOT</b> DUE TO (c) <b>DO NOT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease &amp; failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-10</b> , to <b>12-15</b> , that (I) (we) last saw the deceased alive on <b>12-14</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Trever</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Trever</b>		22d. ADDRESS <b>Easton, Md.</b>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-15-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Chester, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>James K. Daugherty</b>		25a. REC'D BY REGISTRAR <b>DATE 12-21-61</b>	
		25b. REGISTRAR'S SIGNATURE	

(M)

80

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician and complete and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14483

14450

PLACE OF DEATH

a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EASTON

c. LENGTH OF STAY IN IB

4 wks.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

3. NAME OF DECEASED (Type or print)

ANNA

First

Middle

Beall

HAIR

Last

DATE OF DEATH

Month

Day

Year

12

27

1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

11/23/1904

9. AGE (In years last birthday)

57 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Clinton Beall

14. MOTHER'S MAIDEN NAME

Iula Radcliff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

214 28 3146

17. INFORMANT

Mrs. Helen Patrick, 704 Goldsboro St, Easton, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Hepatic coma

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Massive bleeding from esophageal varices

DUE TO

(c)

Post-necrotic cirrhosis of the liver

INTERVAL BETWEEN ONSET AND DEATH

3 days

6 days

Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While ☐ Not While ☐ of work ☐ of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from... 19... to... 19... that (I) (we) last saw the deceased alive on... 12-26-1961... and that death occurred at... 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Robert W. Trever

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

12/30/1961

23c. NAME OF CEMETERY OR CREMATORY

Greenmount Cemetery

23d. LOCATION (City, town or county)

Hillsboro Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W. Hampton Givell EASTON, Md.

25a. REC'D BY REGISTRAR

DATE JAN 3 '62

25b. REGISTRAR'S SIGNATURE

William S. Kline



## CERTIFICATE OF DEATH

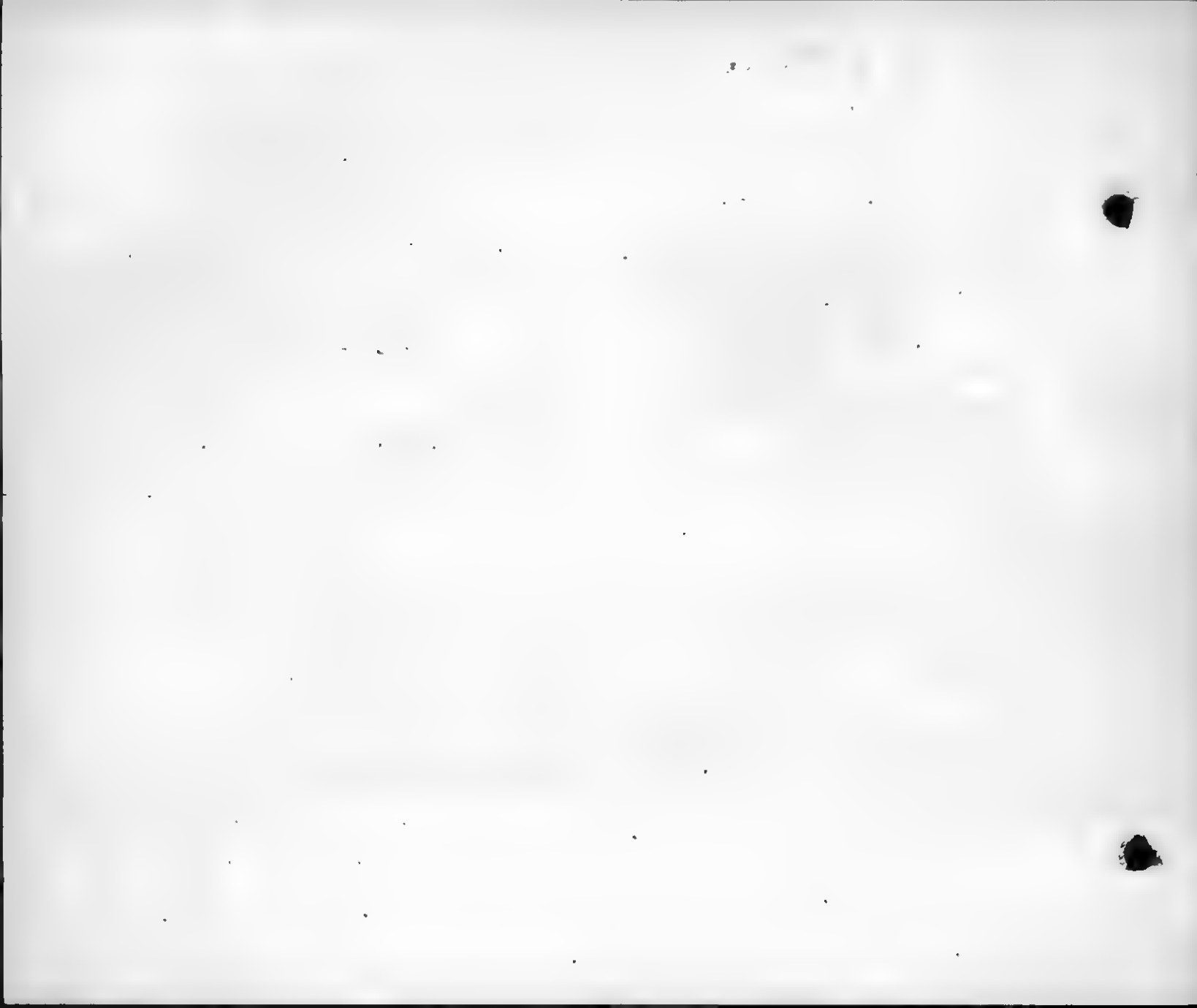
Reg. Dist. No. 14451

14484

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Easton Memorial Hospital</b>		d. STREET ADDRESS <b>7724 Annapolis Road</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Martina R. Haynes</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 10, 1883</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	IF UNDER 24 HRS Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>District Gov't Clerk</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Julius Juenemann</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Stiver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Charles B. Finn</b>		Address <b>Lanham Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>20 Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 19, 1961</b> to <b>Dec. 14, 1961</b> , that I last saw the deceased alive on <b>Dec. 14, 1961</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Irvin G. Hoyt</b> M.D.		ADDRESS (Street, city or town, state) <b>Queenstown, Md.</b> DATE SIGNED <b>12/15/61</b>	
PHYSICIAN'S NAME (Type) <b>Irvin G. Hoyt M.D.</b>		<b>Queenstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/18/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 18 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14452

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL EASTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ENGLISH</b> Last <b>HENDERSON</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 23, 1888</b>
9. AGE (In years lost birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
11. BIRTHPLACE (State or foreign country) <b>INDIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES ENGLISH HENDERSON</b>		14. MOTHER'S MAIDEN NAME <b>IDA M. LYNN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. CHAS. E HENDERSON Jr - EASTON, MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting aneurysm</b> 4. IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mediastinitis cystic</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-6-</b> 19 <b>61</b> , to <b>12-7-</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12-7-</b> 19 <b>61</b> , and that death occurred at <b>12</b> A.M. from the causes and on the date stated above			
22a. SIGNATURE <b>Donald F. Bartley</b> M.D.		22b. DATE SIGNED <b>12-7-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD F. BARTLEY</b>		22d. ADDRESS <b>Easton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>12/9/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SPRING HILL</b>	23d. LOCATION (City, town, or county) (State) <b>EASTON MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hoad</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Hoad</b> DATE <b>12-1-61</b>	
25b. REGISTRAR'S SIGNATURE			

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14453

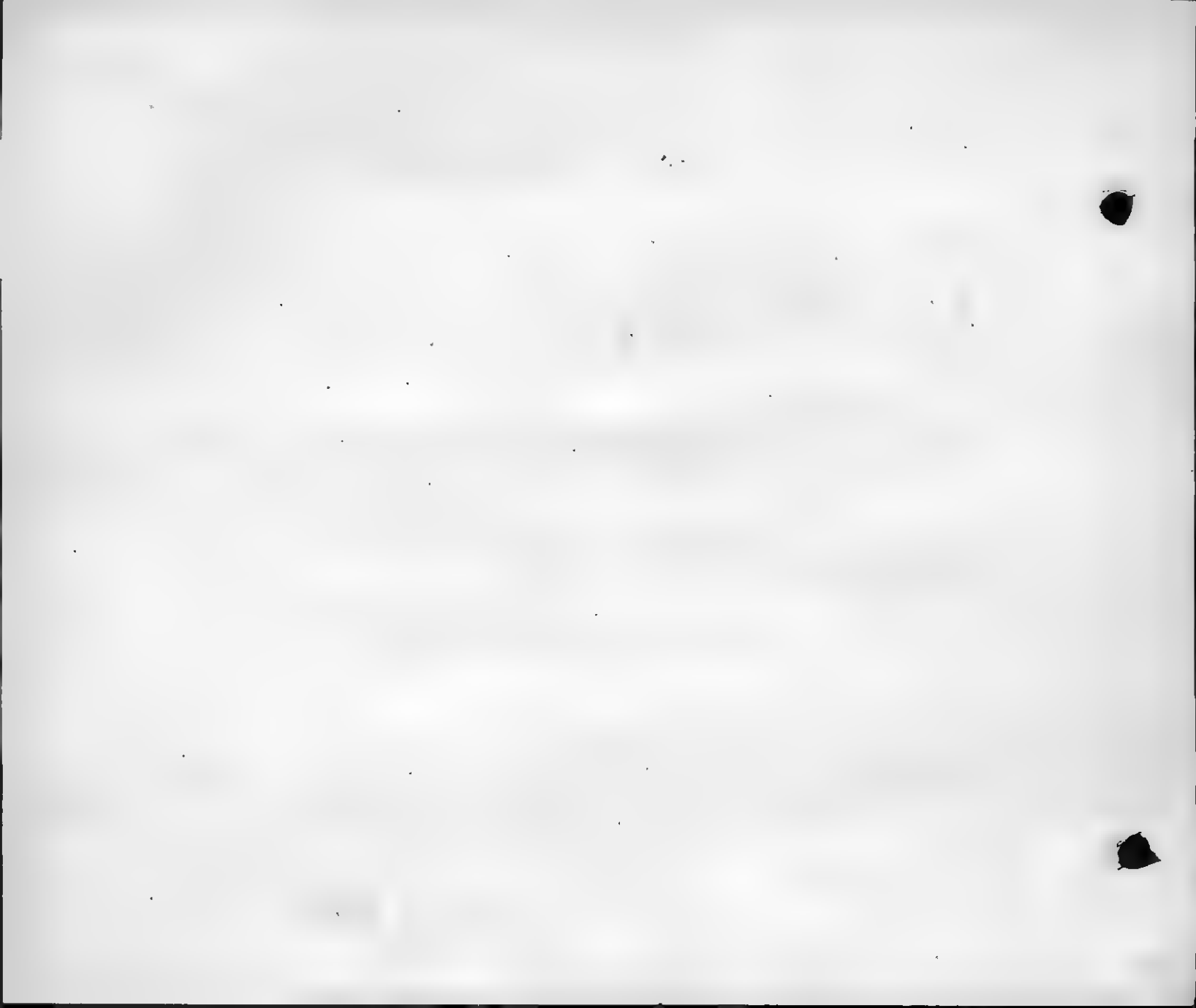
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>19 hrs-30 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Washington Jenkins</u>				4. DATE OF DEATH Month Day Year <u>Dec 7 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 16, 1928</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>John-Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Korean</u>				16. SOCIAL SECURITY NO. <u>313-22-687</u>		17. INFORMANT <u>Gladys-Jenkins-TRAPPE, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leute Hemorrhagic pneumonia</u> <u>570.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Volulus of ileum</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>12/7/61</u> , 19____, and that death occurred at <u>1:40</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>E. C. H. Schmidt</u>				22b. DATE <u>8 Dec 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 10, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>TRAPPE Cem.</u>		23d. LOCATION (City, town, and county) (State) <u>TRAPPE, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty - Easton, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>12/11/61</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>	



may be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. H. H. Man</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James M. Johnson</b>		4. DATE OF DEATH <b>Dec 13, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR: Months <b>12</b> Days <b>13</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Waterman</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Annie Henson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-102358</b>	
17. INFORMANT <b>Mrs. Helen C. Johnson - Wittman, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Dis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>20 Sept 1957</b> to <b>13 Dec 1961</b> , that (I) (we) last saw the deceased alive on <b>12 Dec 1961</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>R. Greene C. H. H. Man</b>		22b. DATE SIGNED <b>12-14-61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hammondtown Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Easton, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Brackbill - Easton, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 29 '61</b>	
25b. REGISTRAR'S SIGNATURE			



1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURRSTVILLE</b>	
c. LENGTH OF STAY IN lb <b>4 days</b>		d. STREET ADDRESS <b>1521</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Kelley</b> Last <b>Kelley</b>		4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 18, 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ANDREW WILLOUGHBY</b>		14. MOTHER'S MAIDEN NAME <b>EMILY WILLOUGHBY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>WALTON WILLIS, DENTON, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.2</b> DUE TO <b>ASHD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASHD</b> DUE TO (c) <b>YRS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12.3.1961</b> to <b>12.3.1961</b> , that (I) (we) last saw the deceased alive on <b>12.3.1961</b> , and that death occurred at <b>4:07 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>S. Krech</b>		22b. DATE SIGNED <b>12.3.61</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. Krech M.D.</b>		22d. ADDRESS <b>Easton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>DEC 5, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DENTON</b>	23d. LOCATION (City, town, or county) (State) <b>DENTON, MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. [unclear]</b>		25a. REC'D BY REGISTRAR <b>DEC 8 '61</b>	
ADDRESS <b>more than Denton, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[unclear]</b>	

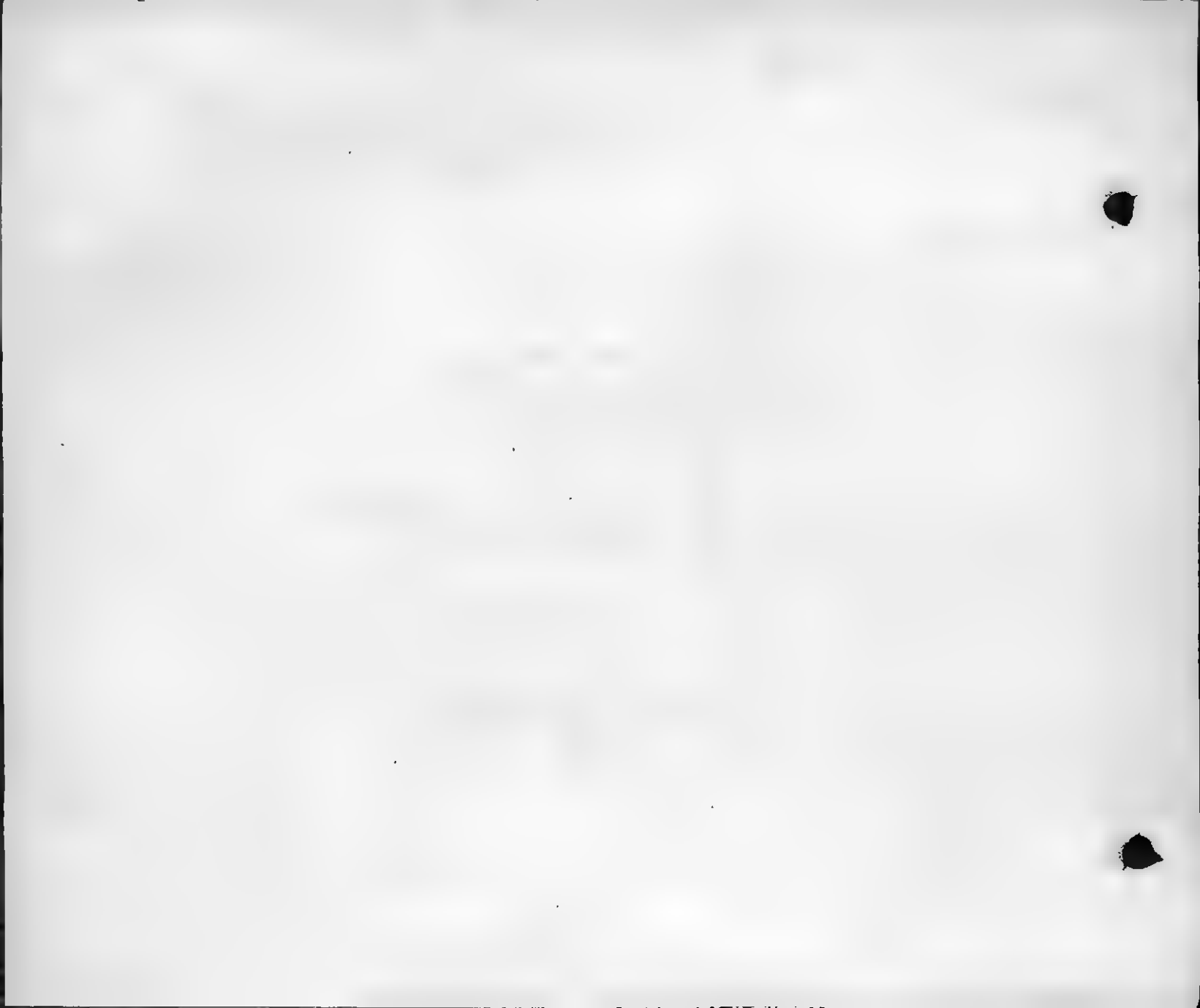


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completed certificate be filed in by the funeral director, page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14489  
CERTIFICATE OF DEATH  
14456

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> <u>3da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Goldsboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) <u>Elva</u> First <u>E.</u> Middle <u>Kemp</u> Last		4. DATE OF DEATH <u>12</u> Month <u>27</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2, 1893</u> <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Draper</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mitchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>221-14-6693</u>	
17. INFORMANT <u>Herman Kemp</u>		Address <u>Goldsboro, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute and chronic renal failure (uremia)</u> DUE TO <u>Acute and chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute and chronic pyelonephritis</u> (c) <u>Acute and chronic pyelonephritis</u> DUE TO <u>Acute and chronic pyelonephritis</u> cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk. 1 day</u> <u>1 wk. 1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-24</u> <u>1961</u> , to <u>12-27</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>12-26</u> <u>1961</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Traver</u>		22b. DATE SIGNED <u>December 27, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Traver, M.D.</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-30-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		23d. LOCATION (City, town or county) (State) <u>Greensboro Maryland</u>	
24. FUNERAL-DIRECTOR'S SIGNATURE <u>John E. Boulaing</u>		25a. REC'D BY REGISTRAR <u>JAN 2 '62</u>	
ADDRESS <u>Greensboro Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

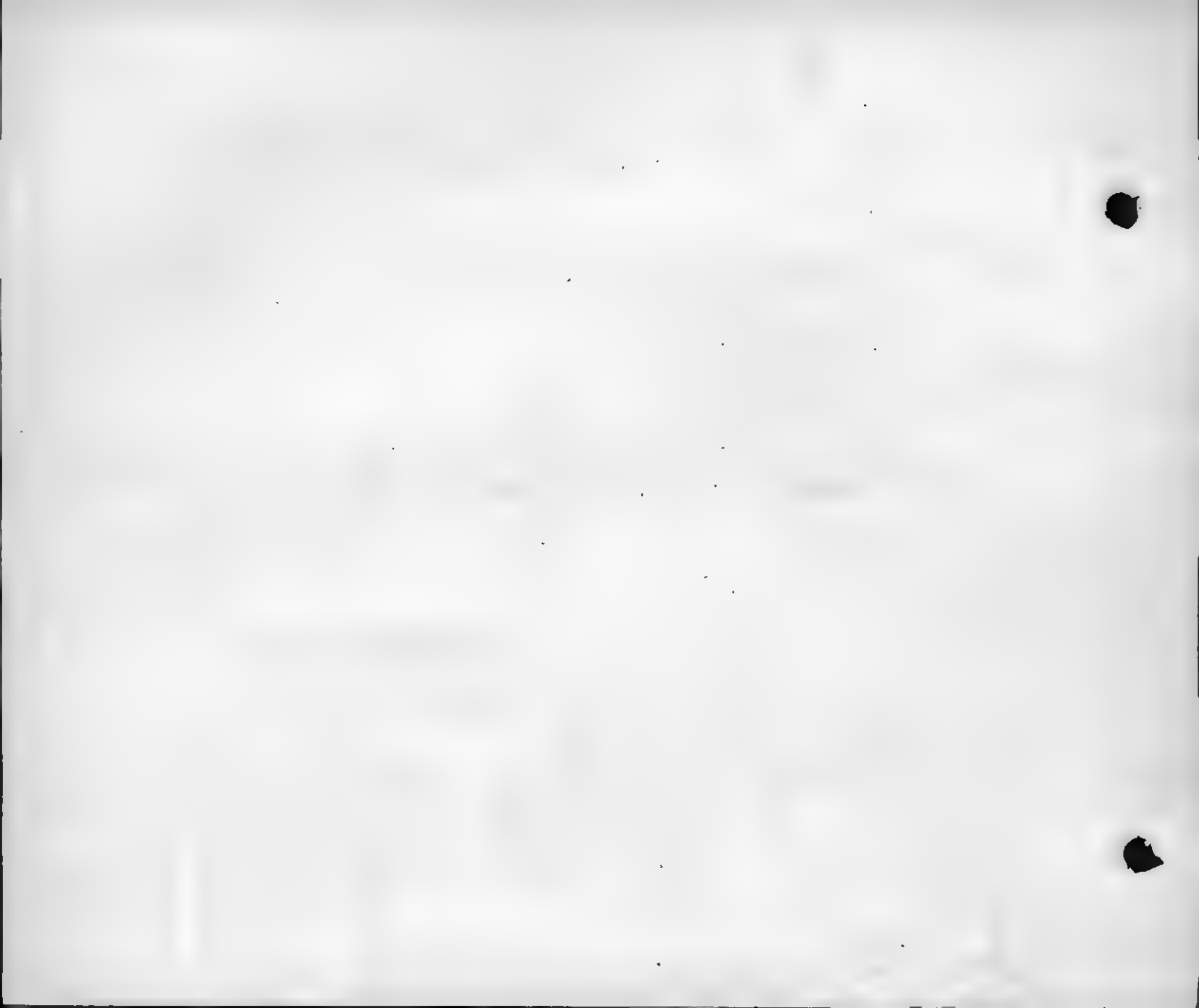




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 1  
may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14490  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
14457  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>1st</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memoirial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Gertrude</u> Last <u>McDaniel</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Col</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-7-32</u>
9 AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHER</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>DAVID H. McDaniel</u>		14. MOTHER'S MAIDEN NAME <u>Ida MAE Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO <u>217-28-2693</u>	
17 INFORMANT <u>Lillie Gertrude Cooper</u> Address <u>Grasonville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septic peritonitis</u> DUE TO <u>Appendiceal abscess</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rhynchodysplasia</u> (c) <u>Pharyngeal abscess</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred <u>12:05</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>E.C.H. Schmidt</u>		22b. DATE <u>20 Dec 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-5-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Robinson Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Grasonville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Schell, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>DEC 4 '61</u>			



TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9, 60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14458											
1. PLACE OF DEATH a. COUNTY <u>talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON, RURAL</u> c. LENGTH OF STAY IN 1b <u>33 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> d. STREET ADDRESS <u>Route 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF (Type or print) <u>Ernest</u> <u>Miller</u> First Middle Last				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1961</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 3, 1895</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>66</u> Days <u>46</u> Hours <u>46</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Saw mill</u>				11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hamp Miller</u>				14. MOTHER'S MAIDEN NAME <u>Dora Miller</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-24-4980</u>				17. INFORMANT <u>Alma Miller</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>MI</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MI</u> <u>MI</u> <u>Exposure to weather</u> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) ACTUAL SIGNATURE <u>Louis N. WELTY</u> M.D. EXAMINER'S NAME (Type) <u>WELTY</u> DATE SIGNED <u>12-29-61</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-29-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>EASTON, Md.</u>			
23. FUNERAL DIRECTOR <u>James R. Doherty, Easton, Md.</u>						24a. REC'D BY REGISTRAR <u>JAN 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the law be retained by the hospital or attending physician. The law also requires that the law be retained by the hospital or attending physician. The law also requires that the law be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14492

CERTIFICATE OF DEATH

14459

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN It <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Queen Anne</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> h. STREET ADDRESS <u>17X 2</u> i. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First Middle Last <u>HERMAN PALMER</u>		4. DATE OF DEATH Month Day Year <u>12 - 21 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>W.L. Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Howe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <u>W. Stewart Palmer--Stevensville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>cerebral atherosclerosis</u> (b) <u>(2) Aspiration pneumonia</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Low small intestinal obstruction (operation 11 Dec '61)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>(?)</u> <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <u>November 19, 1959</u> to <u>21 Dec</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on... <u>21 Dec</u> 19 <u>61</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thurston Harrison</u>		22b. DATE SIGNED <u>21 Dec 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/23/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		23d. LOCATION (City, town or county) (State) <u>Stevensville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		25a. REC'D BY REGISTRAR <u>DEC 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Easton</b> c. LENGTH OF STAY IN b <b>5 hr. 50 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Easton Memorial Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> d. STREET ADDRESS <b>614 Goldsboro St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Charles Arthur Perry</b>	4. DATE OF DEATH <b>Dec 17 1961</b>	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/1898</b>	9. AGE (In years last birthday) <b>63</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Caroline Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Thomas Perry</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Hasler</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Elizabeth Perry, Easton, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Gastric hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Carcinoma of stomach</b> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Myocardial infarction &amp; coronary narrowing</b>		20c. TIME OF INJURY Month, Day, Year <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>11:45 AM</b> to <b>11:45 AM</b> , that (I) (we) last saw the deceased alive on <b>12/21/1961</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>E. C. H. Schmidt</b> M.D.	
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		22d. ADDRESS <b>Easton, Maryland</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE <b>12/21/61</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>12/21/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Easton, Talbot Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hampton Canoll</b> ADDRESS <b>Easton, Md</b>		25a. REC'D BY REGISTRAR <b>DEC 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>W. Hampton Canoll</b>		25c. REGISTRAR'S SIGNATURE <b>W. Hampton Canoll</b>		25d. REGISTRAR'S SIGNATURE <b>W. Hampton Canoll</b>		25e. REGISTRAR'S SIGNATURE <b>W. Hampton Canoll</b>		25f. REGISTRAR'S SIGNATURE <b>W. Hampton Canoll</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

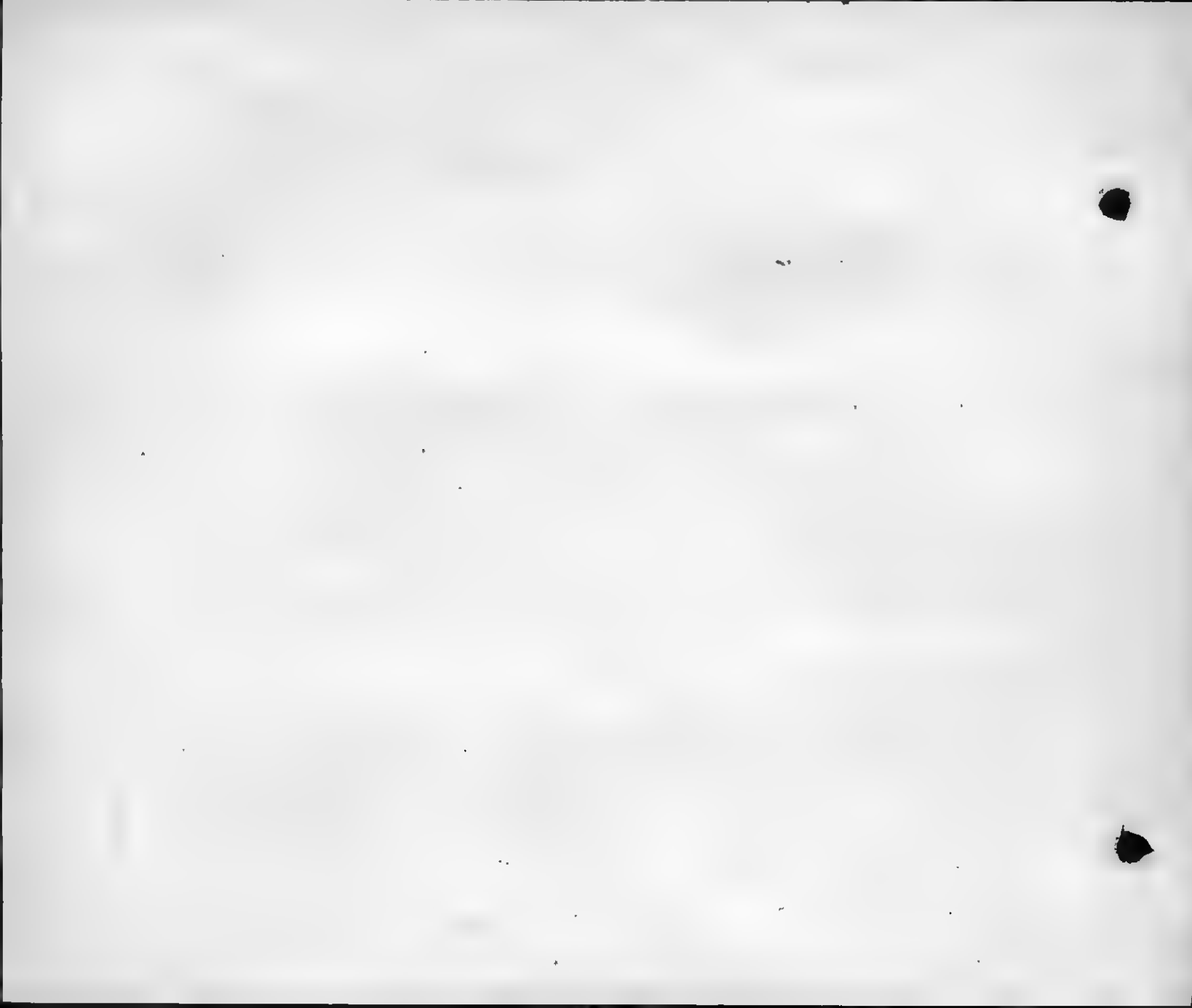
CERTIFICATE OF DEATH

14494

14461

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>29th</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Talbot</u>		3. NAME OF DECEASED (Type or print) <u>Dwayne</u> First <u>Keith</u> Middle <u>Richardson</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 30, 1961</u>		9. AGE (In years last birthday) yrs <u>30</u>		10. IF UNDER 1 YEAR Months <u>30</u> Days <u>0</u>		11. IF UNDER 24 HRS. Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Mr. Larry E. Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Norma Mabe</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr. Larry E. Richardson Avalon, Md.</u>		17. INFORMANT <u>US Coast Guards</u>		Address <u>US Coast Guards</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity</u> 7:15X DUE TO (b) <u>30 hrs.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH		20. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extreme prematurity</u>					
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
24. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		25. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		27. (City or town)		28. (County) (State)	
29. I certify that (I) (this hospital) attended the deceased from <u>1-30-1961</u> to <u>12-1-1961</u> , that (I) <u>last</u> saw the deceased alive on <u>12-1-1961</u> , and that death occurred at <u>12</u> M. from the causes and on the date stated above.									
29a. SIGNATURE <u>Dr. [Signature]</u>		M.D. ATTENDING PHYS <u>[Signature]</u>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		29b. DATE SIGNED <u>12/18/61</u>	
29c. PHYSICIAN'S NAME (Type) <u>Dr. [Signature]</u>		29d. ADDRESS <u>Easton Memorial Hospital</u>		29e. CITY OR TOWN <u>Easton</u>		29f. COUNTY <u>Maryland</u>		29g. STATE <u>Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>incineration</u>		23b. DATE THEREOF <u>12/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Easton Memorial Hospital</u>		23d. LOCATION (City, town, or county) <u>Easton, Maryland</u>		23e. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Easton, Memorial Hospital, Easton, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 20 1961</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE	

2080263XVI



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14495

14462

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u> c. LENGTH OF STAY N 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u> d. STREET ADDRESS <u>Trappe</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph Oliver Roberts</u> First Middle Last <b>4. DATE OF DEATH</b> <u>Dec. 23</u> Month Day Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan. 30, 1906</u>	
<b>9. AGE</b> (In years last birthday) <u>55</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, when it returned) <u>Chapman</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>New York State</u> <b>11. PLACE OF BIRTH</b> (County & State or foreign country) <u>A.S.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>A.S.</u>		<b>13. FATHER'S NAME</b> <u>George Roberts</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>May Kemp</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service) <u>220-34-8311</u> <b>17. INFORMANT</b> <u>Thos. O. Roberts Trappe</u> Address <u>Trappe</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> (b) <u>Chronic Hypertension &amp; Arteriosclerosis</u> (c) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u>None</u> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>October 12-22, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12-22, 1961</u> <b>and that death occurred at</b> <u>10:00 A.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>William L. Winters</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type or print) <u>WILLIAM L. WINTERS</u>		<b>22b. DATE SIGNED</b> <u>12/26/61</u> <b>22d. ADDRESS</b> <u>210 EDOVER EASTON Md.</u>	
<b>23a. BURIAL, CREMATION, etc., DATE THEREOF</b> <u>Dec. 29, 1961</u> <b>23b. NAME OF CEMETERY OR CREMATORY</b> <u>Edford Cem.</u> <b>23c. LOCATION</b> (City, town or county) (State) <u>Edford Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Marion E. Newman &amp; Son</u> ADDRESS <u>Easton Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>DADEC 28 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>12/26/61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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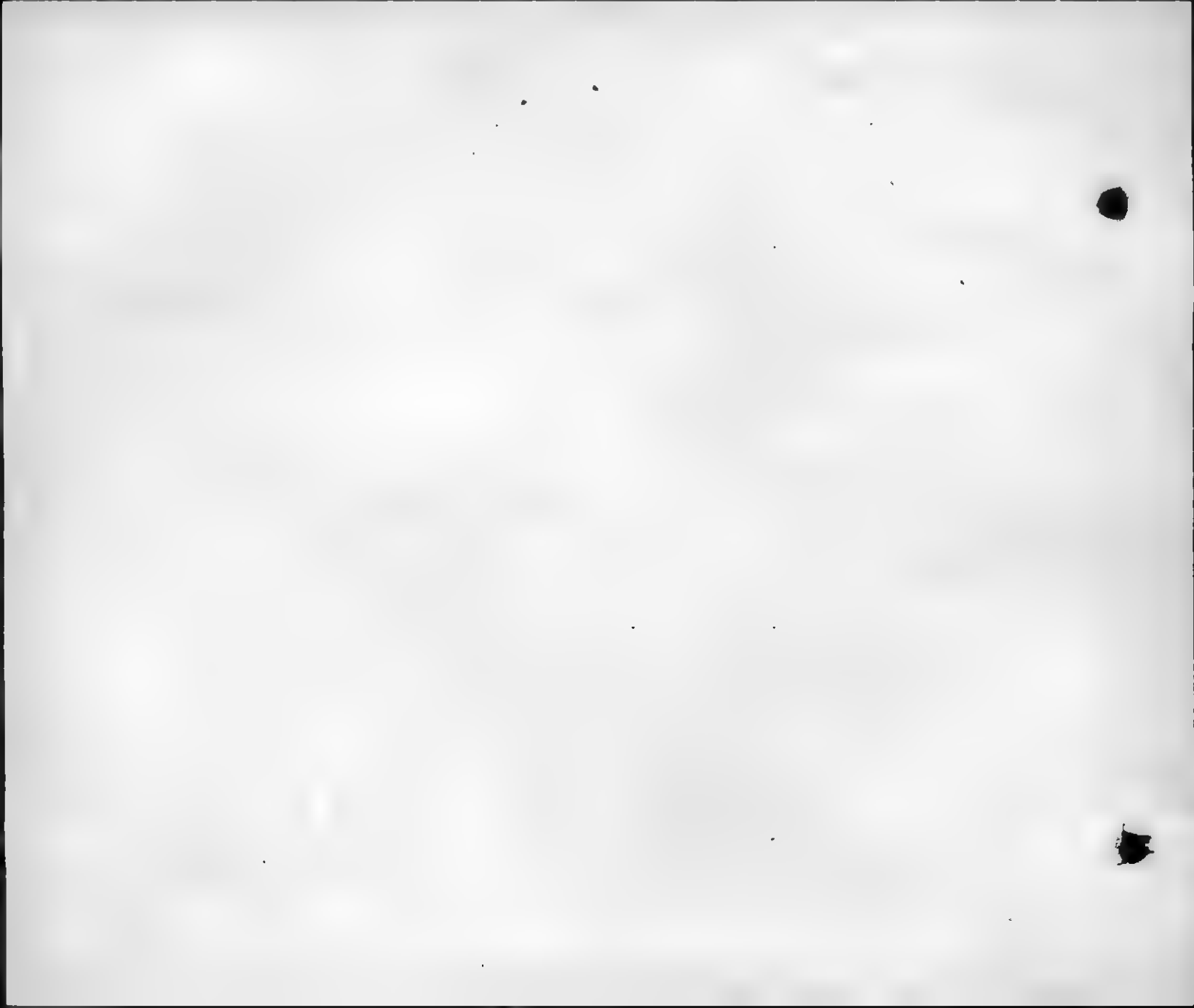
14496  
TALBOT

14672

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY IN 1b <b>5 days</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg</b> d. STREET ADDRESS <b>Box 1678</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Robinson</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Black</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/27/61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Ernest Lee Kicker</b>		14. MOTHER'S M maiden name <b>Shirley Geneva Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Shirley Robinson</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO (b) <b>Premature delivery</b> DUE TO (c) <b>Premature rupture of membranes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4 days</b> <b>4 days</b> <b>5 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>27-Nov-1961</b> to <b>2-Dec-1961</b> , that (I) (we) last saw the deceased alive on <b>2-Dec-1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Hale K. Robinson</b>		22b. DATE SIGNED <b>10-Jan-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dale R. Koffman, MD.</b>		22d. ADDRESS <b>16 N. 2nd St., Denton, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Incinerated</b>	<b>12/16/61</b>	<b>Memorial Hospital</b>	<b>Easton Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Hospital, Easton Md</b>		25. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hinkle</b>			

500023 LX



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. It should be signed by the funeral director. After this certificate has been signed by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

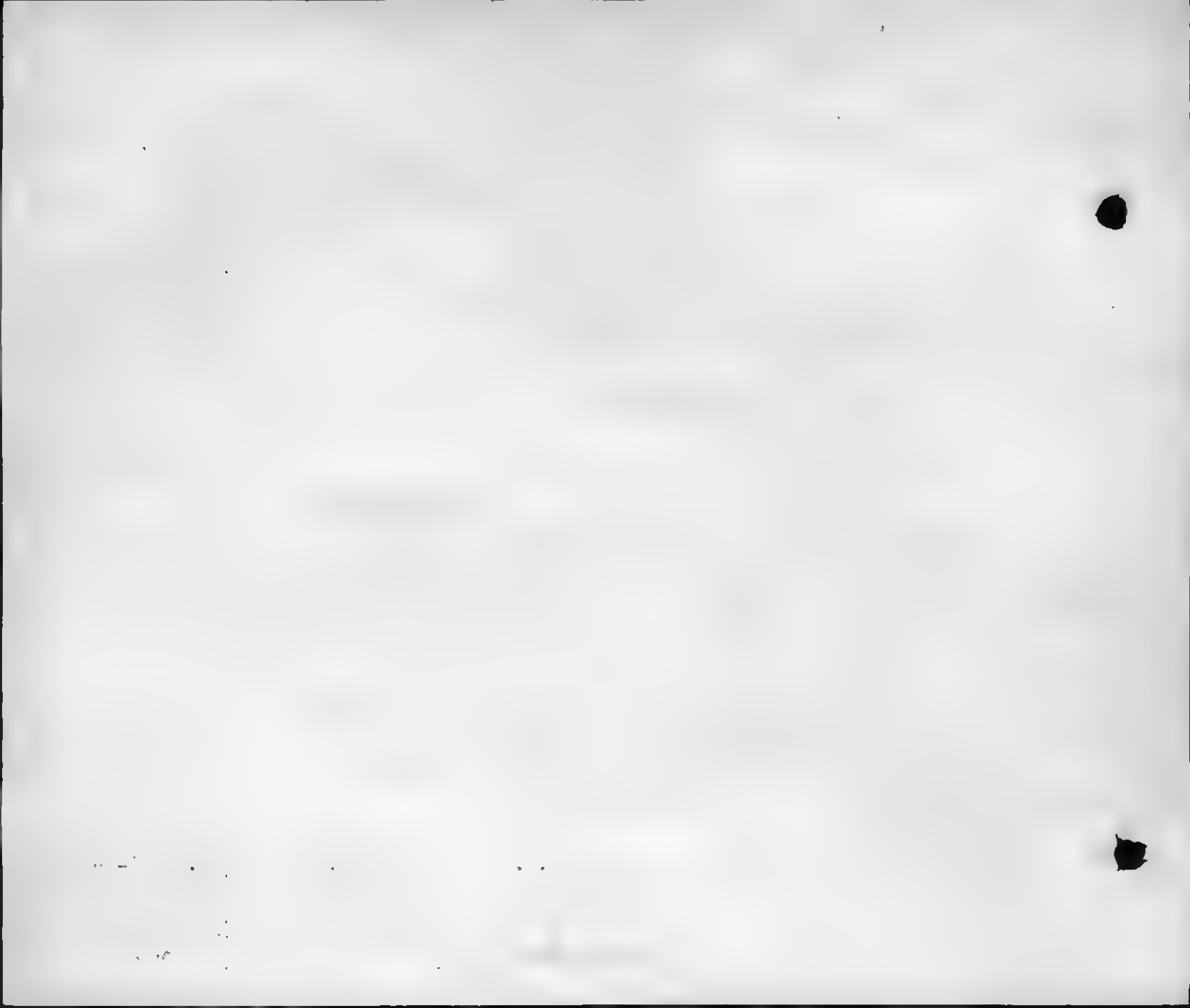
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14497

## CERTIFICATE OF DEATH

14673

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN <u>11 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u> d. STREET ADDRESS <u>178</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Gwendolyn Lenore Rochester</u> First Middle Last <b>5. SEX</b> <u>FEM</u> <b>6. COLOR OR RACE</b> <u>COLORED</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>AUG. 27 - 1961</u> <b>9. AGE</b> (In years last birthday) <u>4</u> yrs. <u>3</u> months <u>3</u> days <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>TALBOT - MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>CLARK ROCHESTER</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>EVA DOUGLAS</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> <u>1-3-62</u> <b>17. INFORMANT</b> <u>Mrs. Rochester Church Hill Md.</u> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diarrhea + Dehydration</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Pneumonia</u> DUE TO (c) <u>2da</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4da</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <u>12-30</u> 19 <u>61</u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Church Hill Md.</u> <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12-30</u> , 19 <u>61</u> , to <u>12-30</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>12-30</u> , 19 <u>61</u> , and that death occurred at <u>8:30</u> from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>John E Baybutt</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>John E. Baybutt</u> <b>22d. ADDRESS</b> <u>M.D. 205 Earle Ave. Easton, Md.</u> <b>22e. DATE SIGNED</b> <u>1-3-62</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u> <b>23b. DATE THEREOF</b> <u>1/1/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Church Hill</u> <b>23d. LOCATION (City, town or county)</b> <u>Church Hill Md.</u> <b>23e. REC'D BY REGISTRAR</b> <u>DATE JAN 9 '62</u> <b>23f. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Harris</u>	





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained at your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14498											
14463											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>MARYLAND</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>McDaniel, RD.</u>											
c. LENGTH OF STAY IN <u>15 yrs</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>at home</u>											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>											
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>McDaniel, RD.</u>											
d. STREET ADDRESS <u>none</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Philip Lee Russ</u>											
4. DATE OF DEATH <u>December 17 19 61</u>											
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>June 23, 1913</u> 9. AGE (In years last birthday) <u>48 yrs.</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>metal work</u>											
10b. KIND OF BUSINESS OR INDUSTRY <u>auto repair</u>											
11. BIRTHPLACE (State or foreign country) <u>Talbot Co., Maryland</u>											
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>George Russ</u>											
14. MOTHER'S MAIDEN NAME <u>Minnie Venton</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WWII</u>											
16. SOCIAL SECURITY NO. <u>220 01 8231</u>											
17. INFORMANT <u>Mrs. Doris I. Russ, McDaniel, RD., Md.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>9.5 W. Chest</u> DUE TO <u>919.9</u> Conditions, if any, which gave rise to immediate cause (b) <u>919.9</u> (c), stating the underlying cause last. <u>919.9</u> DUE TO <u>919.9</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>919.9</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>factory, street, office bldg., etc.</u> 20f. (City or town) <u>Easton, Maryland</u> (County) <u>Talbot</u> (State) <u>Md.</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <u>Natural causes</u> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county) <u>17-18-61</u>											
DATE SIGNED <u>17-18-61</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12/20/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u> 22d. LOCATION (City, town, or country) <u>Easton, Maryland</u> (State) <u>Md.</u>											
23. FUNERAL DIRECTOR <u>Arthur S. Kraus</u> 24a. REC'D BY REGISTRAR <u>DEC 20 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

14499

14464

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Eastern Shore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg - Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		d. STREET ADDRESS <b>Dixon Road</b>	
3 NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Allen</b> Last <b>Skethway</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>6</b> Year <b>1961</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1893</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Quarryville, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William I. Skethway</b>		14. MOTHER'S MAIDEN NAME <b>Abigail A. Skethway</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-2811</b>	
17. INFORMANT <b>Clara A. Skethway, Federalburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Secondary Anemia.</b> DUE TO (c) <b>Chronic Myelogenous Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days -</b> <b>3 years -</b> <b>18 months.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Feb 1957</b> to <b>Dec 1961</b> , that (I) (we) last saw the deceased alive on <b>12-6-1961</b> , and that death occurred at <b>11:35 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H. R. Trapnell</b>		22b. ADDRESS <b>Federalburg, Maryland</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. R. Trapnell M.D.</b>		22d. ADDRESS <b>Federalburg, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Dec. 9, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Federalburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hampton Funeral Home, Federalburg, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 11 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Carl S. Frank</b>		25c. DATE <b>12/7/61</b>	



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN 1b <u>4 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1310 Goldsboro Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Anna Virginia Smith</u>		4. DATE OF DEATH <u>Dec. 7</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Charles Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elliott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>220-26-3412</u>	17. INFORMANT <u>Mrs. Evelyn Neumann</u> Address <u>Wilmington Del.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>JUNE</u> , 19 <u>60</u> , to <u>DEC. 7</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>DEC. 7</u> , 19 <u>61</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred H. Bentley</u> M.D.		22b. DATE SIGNED <u>12-7-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec. 9, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Efford Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Efford Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newcomer</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1961</u>	
ADDRESS <u>Easton Md.</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>	

(M)

(I)



may be filled in by the funeral director, or by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, or the hospital or attending physician, should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14501

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

Item 23b, Film G502 32/18/61 100

14466

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <b>Royce</b> Middle <b>Riker</b> Last <b>Spring</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 23, 1890</b>		9. AGE (In years last birthday) <b>71</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done, and most of working life, even if retired) <b>Retired Brain Surgeon</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Breton B. Spring</b>		14. MOTHER'S M maiden name <b>Betsy Royce</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Royce Spring</b> Address <b>Efford Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gastric Hemorrhage</b> DUE TO (b) <b>Esophageal varices</b> DUE TO (c) <b>Cirrhosis of liver</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that (I) (this hospital) attended the deceased from <b>1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 10, 1961</b> , and that death occurred at <b>2:08 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>E. C. H. Schmidt</b>		22b. DATE <b>10 Dec 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		22d. ADDRESS <b>Easton, Maryland</b>		22e. MED. DIRECTOR <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 12, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Efford Cemetery</b>		23d. LOCATION (City, town, or county) <b>Efford Md.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		25a. REC'D BY REGISTRAR <b>DEC 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. Thomas</b>					

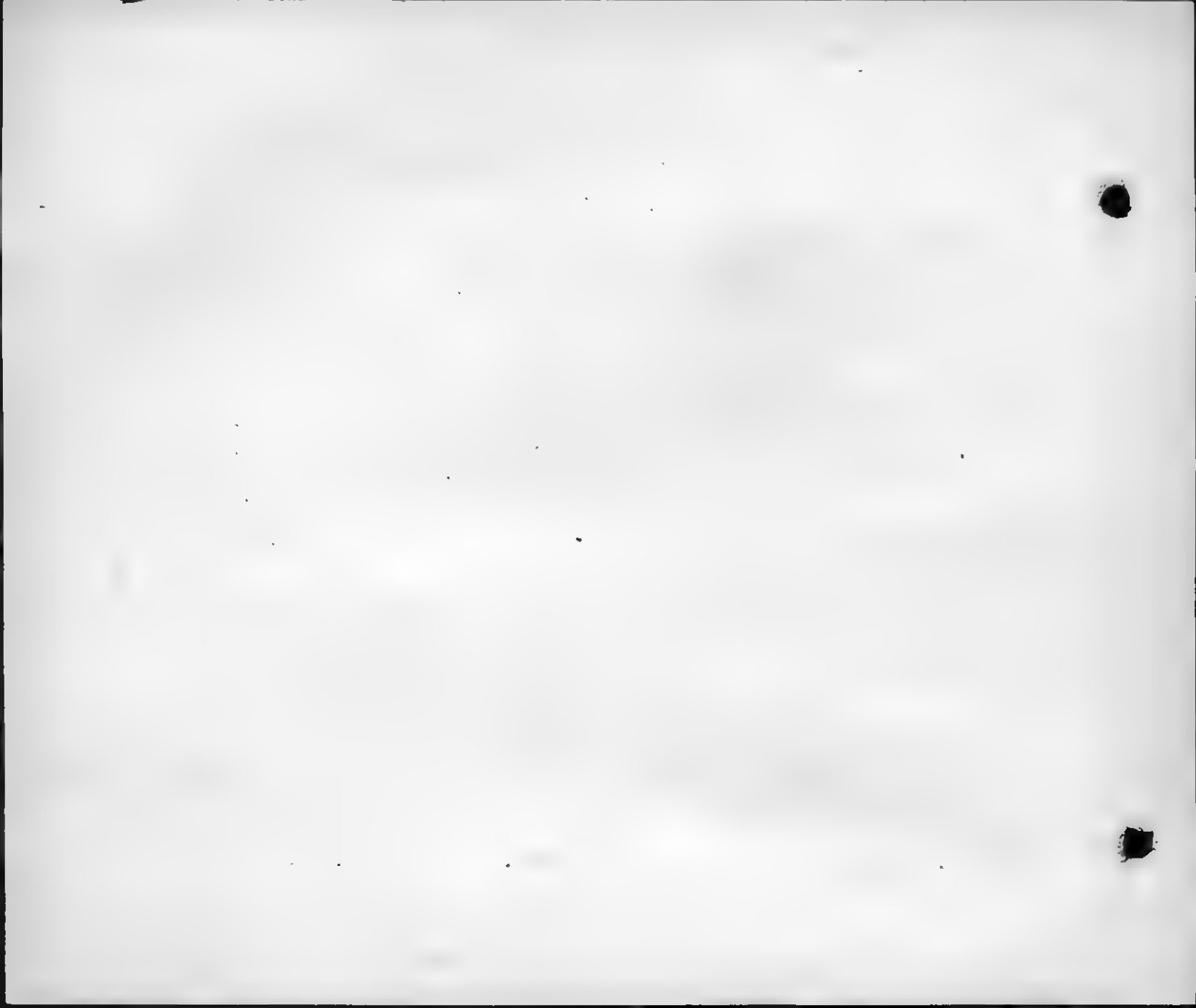




## CERTIFICATE OF DEATH

1462

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL ROYAL OAK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>K.</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>4</b> Year <b>1961</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 15 - 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MERCANTILE STORE</b>	
11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>CHARLES C. KRAUSE</b>		14. MOTHER'S MAIDEN NAME <b>CHARLOTTE WALKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>214-10-7892</b>	
17. INFORMANT <b>MRS PAUL HOLMES</b>		Address <b>1368 CROWN BROWN RD FARMINGTON CT 06030</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-21</b> DUE TO <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Supertensive Cardiovascular Dis</b> DUE TO <b>5 yrs.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14-15</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>July</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 1958</b> to <b>4 Dec 1961</b> , that (I) (we) last saw the deceased alive on <b>4 Dec 1961</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>R. Lane Wroth</b>		22b. DATE <b>5 Dec 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. Lane Wroth</b>		22d. ADDRESS <b>M.D. St. Michaels, Maryland 12/5/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/16/61</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE</b>	23d. LOCATION (City, town, or county) (State) <b>PIKESVILLE MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert</b>		25a. REC'D BY REGISTRAR <b>DEC 7 '61</b>	25b. REGISTRAR'S SIGNATURE <b>James S. Harris</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician, the law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14503

14468

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>W. H. M. A. R.</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>C</u> Middle <u>W. H. M. A. R.</u> Last		4. DATE OF DEATH <u>December 20</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23 1887</u> 74 yrs
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
10a. BIRTHPLACE (County and State) <u>MARYland</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. FATHER'S NAME <u>William WARNER</u>		12. MOTHER'S MAIDEN NAME <u>Elizabeth WARNER</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		14. SOCIAL SECURITY NO. <u>Lillie WARNER - W. H. M. A. R., Md.</u>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pyelonephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of the bladder</u> DUE TO cause last, (c)		16. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> to <u>1961</u> , that (I) (we) last saw the deceased alive on <u>1961</u> , and that death occurred at <u>9:00 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u> M.D.		22b. DATE SIGNED <u>26 Dec 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-31-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. M. A. R.</u>		25a. REC'D BY REGISTRAR <u>JAN 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

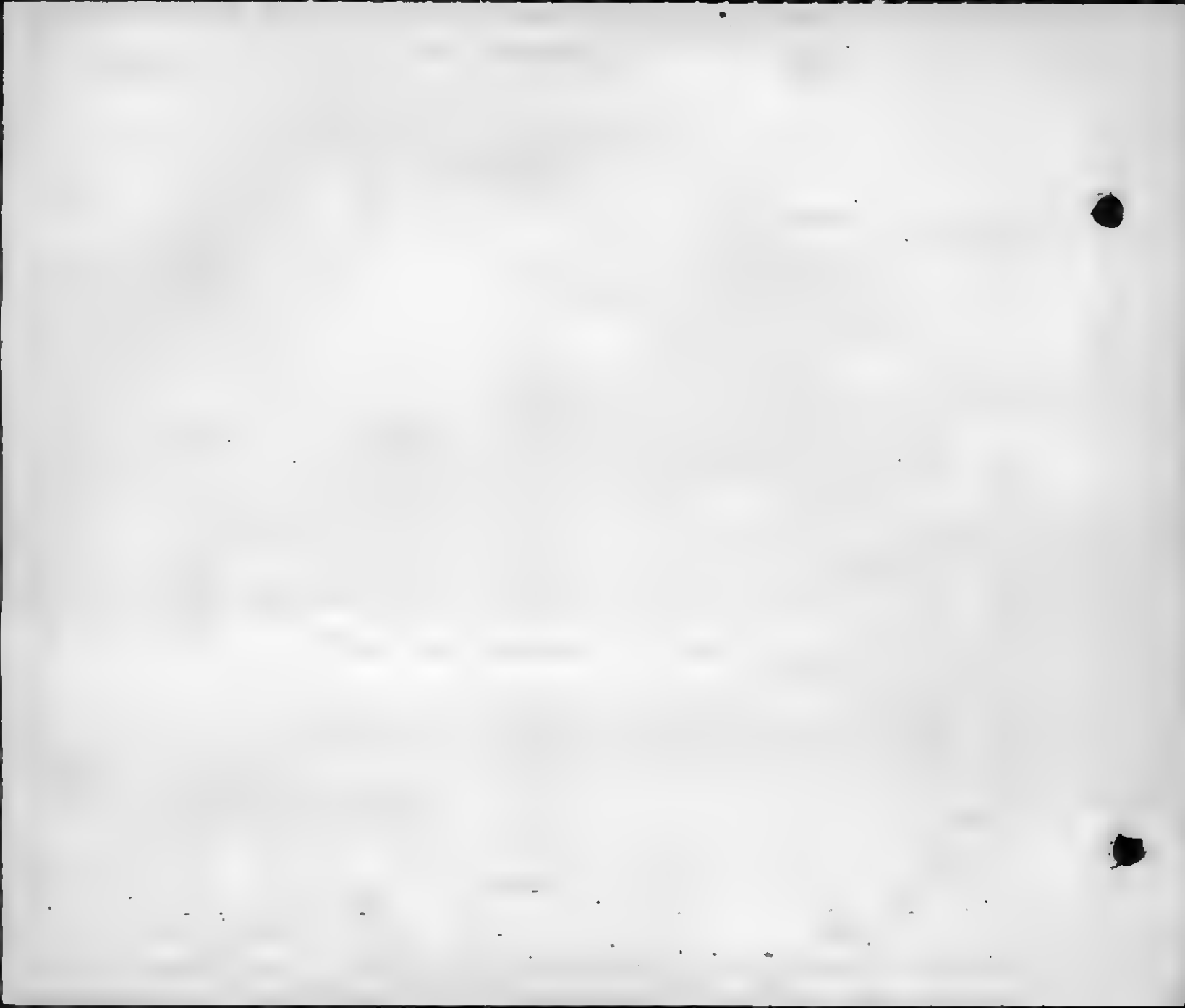
14504

CERTIFICATE OF DEATH

Reg. Dis. No. 1469

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somers et.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>Dec. 15, 1961</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station 19x-2</u>	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Rebecca Frances Watkins</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1961</u>
9. AGE (In years last birthday) yrs <u>2</u> Months <u>20</u> Days <u>20</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Alice Pearle Watkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Myrtle White</u>		Address <u>Chester Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>broncho-pneumonia</u> <u>several days</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>baby was brought into office monitored Dec. 15, 1961</u> DUE TO lying cause lost. (c) <u>at 8 A.M. sent to Memorial Hospital Easton Md</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>th</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 15</u> , 1961, to <u>Dec 15</u> , 1961; that I last saw the deceased alive on <u>Dec 15</u> , 1961, and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Stevensville Maryland</u> DATE SIGNED <u>Dec 15, 61</u> ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D. PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER M.D. STEVENSVILLE MARYLAND</u>			
22a. BURIAL, CREMATION, or other disposal (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY or CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec. 16, 1961</u>	<u>Family</u>	<u>Marion Sta., Md., Som. Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Stark-Meiron Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 22 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles H. Stark</u>

200-31XV



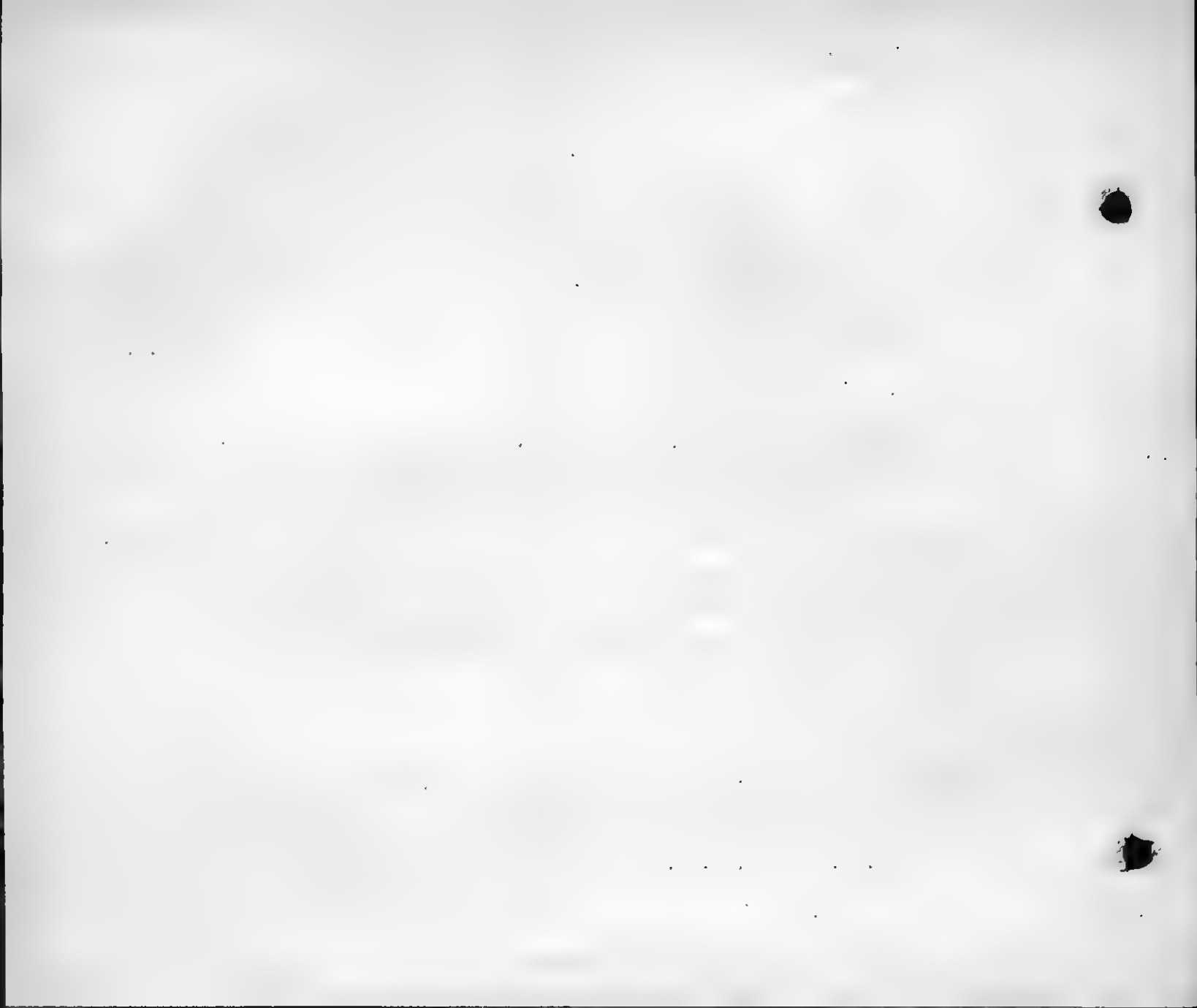
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14505

14470

1 PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastw.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>			
c. LENGTH OF STAY IN 1b <b>11 days</b>				d. STREET ADDRESS <b>East Central Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastw. Memorial Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Perry</b> Last <b>Wright</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>3</b> Year <b>1961</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 15, 1886</b>	
9. AGE (In years lost birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Lumber Yard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
13. FATHER'S NAME <b>James B. Wright</b>				14. MOTHER'S MAIDEN NAME <b>Annie Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>World War I</b>				16. SOCIAL SECURITY NO. <b>21-21-5524</b>			
17. INFORMANT <b>W. E. Lennon</b>				Address <b>Federalsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> <b>Second attack</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Coronary Occlusion</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 minutes</b> <b>Nov. 22, 1961</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Nov. 22, 1961</b> to <b>Dec. 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 3, 1961</b> , and that death occurred at <b>HA</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W. E. Lennon</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>W. E. Lennon, M. D.</b>	
22d. ADDRESS <b>Federalsburg, Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Dec. 7, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Will Crest Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Prampton Funeral Home</b>				ADDRESS <b>Federalsburg, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 6 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>W. E. Lennon</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATIS (4)  
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14506

14471

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN It <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL Hospital</b>				d. STREET ADDRESS <b>R.F.D. #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>LOUISE</b> Last <b>WRIGHT</b>				4. DATE OF DEATH Month <b>12</b> - Day <b>30</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 21, 1961</b>	9. AGE (In years last birthday) yrs. <b>2</b> Months <b>9</b> Days <b>9</b>	IF UNDER 1 YEAR Hours <b>9</b> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pleze Williams</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Wright</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Bertha Wright, Hurlock, Md., R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>491X</b> DUE TO <b>Purulent meningitis</b> <b>Bilateral Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>4:50</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>E.C.H. Schmidt</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <b>3/14/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>E.C.H. Schmidt</b>				22d. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 2, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hurlock, Maryland, R.F.D.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton &amp; Son</b>				ADDRESS <b>Federalsburg, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 3 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14507

14472

<b>1. PLACE OF DEATH</b> a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN <u>106 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>204 S. Harrison</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mildred</u> <u>Myers</u> <u>Wrightson</u> First Middle Last		<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>22</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>aug 30, 1884</u>
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Neuna</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>William B. Myers</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Chapman</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Mrs. Francis D. Wrightson</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro malacia</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio sclerosis (Cerebral)</u> (c) <u>  </u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 mo - 3 years -</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. TIME OF INJURY</b> Month, Day, Year <u>IV</u> Hour a.m. <u>  </u> p.m. <u>  </u>	
<b>20c. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
<b>20e. (City or town)</b> <u>  </u>		<b>20f. (County)</b> <u>  </u> (State) <u>  </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12-20</u> <b>to</b> <u>12-22</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12-20</u> <b>and that death occurred at</b> <u>11:30</u> <b>AM, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>William L. Winters</u>		<b>22b. DATE SIGNED</b> <u>12/23/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>WILLIAM L. WINTERS</u>		<b>22d. ADDRESS</b> <u>210 E. Dorer Easton Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Dec. 26, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Spring Hill Cem.</u>		<b>23d. LOCATION</b> (City, town or county) <u>Easton</u> (State) <u>Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Maurice E. Neumann &amp; Son</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 29 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>  </u>	

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*